NRHA
RURAL MINORITY HEALTH
Resource Book

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SCHOOL OF NURSING, UNIVERSITY OF CENTRAL FLORIDA
COLLEGE OF HEALTH AND PUBLIC AFFAIRS

NATIONAL RURAL HEALTH ASSOCIATION

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IN APPRECIATION

To the National Rural Health Association and the federal Office of Rural Health Policy — *for their commitment to the rural minority initiative.*

To the members of the NRHA Rural Minority Health Committee — *for sharing their insights and wisdom.*

To Rosemary McKenzie — *for leading the way and giving me the opportunity to be part of the journey.*

To my husband, Jack — *for his patience.*

To my parents, Peter and Rose Silbernagel.

PREFACE

America has been called a melting pot, but it seems better to call it a mosaic, for in it each nation, people or race which has come to its shores has been privileged to keep its individuality, contributing at the same time its share to the unified pattern of a new nation. (King Baudouin I of Belgium, 1930-1933)

CENSUS 2000 confirmed that this past decade the United States population became ever more diverse — racially and ethnically. With increasing numbers of people who are of mixed races, metaphorically, the complexion of American society could be described as "café au lait." Our national culture could be described as a "stew" or "salad" — a blend of people with distinct ethnic preferences. Even the predominant minority groups (Americans of African, Hispanic, Asian, Pacific Islander, Native Indian and Eskimo descent) differ greatly in their cultural beliefs, health behaviors and extent of acculturation into mainstream society, that being white, middle class, Anglo-European in origin. Sometimes even Anglo-American consumers have beliefs and lifestyles that seem quite unusual to health professionals who are of similar origin but of a different ethno-cultural orientation.

Diversity has become a priority at all levels of federal, state and local governments as well as in the private sector. Diversity and its ramifications are of utmost concern in the educational and health care delivery sectors! Political correctness, cultural diversity, affirmative action, and equal opportunity are on the forefront of political agendas and university curricula and with corporations' human resource departments. In the health care system, concerns about cultural diversity juxtapose curtailment of escalating costs while ensuring quality and appropriate services to consumers. Consequently, the focus of health care has shifted from a model of "offering more is better" to that of "providing appropriate and acceptable services by culturally competent providers to consumers with diverse belief systems."

Policy makers, program planners and caregivers must respond and develop appropriate strategies that fit the health care needs and expectations of highly diverse clients. Rural communities may, however, face some unusual or additional challenges in meeting this goal associated with their social structures and fragile economic infrastructures.

The National Rural Health Association (NRHA) has been a leader in advocating for rural minorities! For more than a decade, the NRHA assumed a leading role in the rural minority cultural competency initiative along with the Office of Minority Health, Department of Health and Human Services (DHHS), and the federal Office of Rural Health Policy (HRSA). The NRHA has a history of commitment to rural minority communities evidenced by these organizational goals:

- To eliminate health disparities and improve access to quality health care services.

- To enhance the knowledge of rural racial and ethnic minority health care needs related to access to services and treatment.

- To improve the overall access to appropriate and culturally responsive health services.

- To increase and improve communication between community services and programs that affect rural racial and ethnic minority populations.

More specifically, in 1988 the NRHA established its Rural Minority Health Advisory Committee. Committee members included African Americans, Asian Americans, Hispanic/Latinos, and Native Americans who represent rural- and minority-responsive national associations and professional organizations. The following activities have been conducted under the auspices of the NRHA in response to this committee's recommendations:

- In May of 1991 the NRHA began offering minority-focused sessions at the annual national conference and at other NRHA-sponsored events and educational programs.

- In November of 1993 the NRHA convened its first invitational conference, *A Shared Vision: Building Bridges for Rural Health Access*, in Albuquerque, NM. Proceedings of that event were developed, published, and disseminated by the NRHA.

- In March of 1995, the 1st Annual Rural Minority Health Conference, having the theme *Expanding the Bridge: Sharing the Vision*, was held in Long Beach, CA.

- In September of 1996, the 2nd Annual Rural Minority Health Conference, having the theme *Bringing Resources to Bear on the Changing Health Care System*, was held in Birmingham, AL. Proceedings of that conference were published and disseminated by the NRHA.

- In February of 1997, the NRHA convened a national working meeting in Tucson, AZ, to develop a rural minority action agenda that could bring about change at the national level. The product of that meeting was a dynamic strategic planning document ("living document") titled *A National Agenda for Rural Minority Health*. Later that year (November 1997), the NRHA Board of Trustees approved and adopted the National Agenda and its strategic plan as part of the Association's mission.

- In December of 1997, the 3rd Annual Rural Minority Health Conference was held in Charleston, SC, having the theme *Rural Minority Health: Issues for the 21st Century: A Working Conference*. At that event, the preliminary draft of the *National Agenda for*

Rural Minority Health was revised, updated, and expanded. Subsequently, it was published and disseminated by NRHA (April 1998).

- In April of 1998 the NRHA Board of Trustees appointed its first standing Rural Minority Health Committee.

- In December of 1998, the 4th Annual Rural Minority Health Conference, having the theme *Rural Minority Health in the 21st Century: Eliminating Disparities*, was held in Santa Fe, NM. The *National Agenda for Rural Minority Health* provided the overarching theme for that event. At that meeting, the *National Agenda* was again updated to reflect changes in federal policies and in the health care industry. Proceedings of the conference were published and disseminated by the NRHA.

- In May of 1999, the revised *National Agenda for Rural Minority Health* was disseminated by the NRHA.

- In May of 1999 an issue paper titled *A National Agenda for Rural Minority Health — An Overview* was approved and adopted by NRHA's Rural Health Policy Board. That document was published and disseminated by the NRHA and is included in the appendices of this text. (APPENDIX A)

- In September of 1999, the Federal Office of Rural Health Policy funded a Rural Minority Health Initiative to implement the recommendations contained in the *National Agenda for Rural Minority Health.*

- In October of 1999, the NRHA created a Minority Affairs Department within the Association. Mrs. Rosemary McKenzie from the NRHA was appointed as the Minority Affairs Director.

- In December of 1999, the 5th Annual Rural Minority Health Conference, having the theme *Community Voices Calling Us to Action*, was held in Denver, CO. The first meeting of the ORHP-funded Rural Minority Health Initiative Work Group was held in conjunction with the conference. The agenda for the work group was to prioritize the recommendations put forth in the *National Agenda for Rural Minority Health* and to develop implementation strategies.

- In April of 2000, the 2nd meeting of the Rural Minority Health Initiative Work Group met in Kansas City, MO. The meeting agenda focused on developing a plan to implement the strategies put forth in the *National Agenda for Rural Minority Health.*

- In May of 2000, in conjunction with the NRHA Annual Conference held in New Orleans, LA, the Rural Minority Health Committee provided an update on the Rural Minority Health Initiative Work Group's activities.

- In November of 2000, two more Rural Minority Health Issue Papers were presented in New Orleans to the Rural Health Policy Board for approval and adoption; (1) *Need for Standardized Data and Information Systems*; and (2) *Recruitment and Training of Health Professionals*. Both papers are included in the appendices of this text. (APPENDIX B; APPENDIX C)

- In December of 2000, the 6th Annual Rural Minority Health Conference, having the theme *Involving Youth in the Future of Rural Minority Health*, convened in Savannah, GA. Proceedings of that event were published and disseminated by the NRHA.

- In May of 2001, the 3rd Rural Minority Health Issue Paper, titled *The Need for Responsive Rural Health Delivery Systems*, was taken under consideration by the Rural Health Policy Board for approval and adoption. (Refer to APPENDIX E.)

- Currently the 4th Rural Minority Health Issues Paper is being developed for consideration and adoption by the NRHA Policy Board, *Health Policy and Practices*.

- In December of 2001, the 7th Annual Rural Minority Health Conference, having the theme *Rural Minority Women and Their Families: Reaching Out and Reaching Goals in the New Century*, convened in San Antonio, TX. A compendium of speaker handouts will be developed and disseminated.

The *Rural Minority Health Resource Book* is a product of a partnership between the NRHA and the ORHP. The overarching goal of this text is to provide timely and accessible information to a range of audiences about minorities living and working in rural America. The information included herein could be useful for developing appropriate and acceptable health care to diverse populations and ultimately eliminate minority health disparities!

This *Resource Book* is organized along nine chapters with appendices. Chapter 1 and Chapter 2 present demographic patterns and trends that reflect national diversity along with anthropological concepts related to culture and ethnicity. The next four chapters examine in greater detail the health status, cultural characteristics, and linguistic preferences of four predominant minority groups in the United States, specifically African Americans (Blacks) (Chapter 3), Native American and Alaska Natives (Chapter 4), Asians and Pacific Islanders (Chapter 5), and Hispanic/Latinos (Chapter 6). The last three chapters focus on the development of cultural linguistic competence at the individual level (Chapter 7), the organizational level (Chapter 8), and in research and evaluation activities (Chapter 9). The rural perspective is integrated throughout the various chapters.

Each chapter begins with behavioral objectives and concludes with a list of discussion questions. The discussion questions could be used for diversity awareness programs and in educational offerings that focus on cultural linguistic competence.

In the past year there has been a proliferation of Internet sites devoted to the topics of diversity and culture linguistic competence. Thus, an extensive but by no means comprehensive listing of bibliographic resources is included at the end of each chapter. The lists include citations from the literature as well as addresses for Internet sites (World Wide Web [www]) to facilitate accessing up-to-date information relevant to the chapter. Every effort has been made to ensure that URL addresses are accurate and current. However, the Internet is a dynamic media form; accordingly, website addresses change. Some of the citations refer to "search engines" and "portals" that include additional hypertext (web) links to other relevant Internet sites. The links are updated regularly and provide another way to access timely information on a topic of interest. Essentially, the *Resource*

Book is designed to be starting point to access additional and current information specific to a particular community or ethnic group.

Interspersed throughout *The Rural Minority Health Resource Book* are maps, figures, tables, charts, assessment tools, and appraisal checklists that could be used by individuals or organizations to develop, implement, and evaluate cultural and linguistic competence.

I must also comment about the accuracy of census data included herein. While this text was written, intermittent reports for CENSUS 2000 were put out by the Bureau of the Census as data from individual states were compiled. In other words, the numbers kept changing! As this text goes to press, analysis of CENSUS 2000 is not yet complete. Every effort has been made, however, to accurately reflect in this resource text demographic patterns and trends related to minorities, in particular those in rural areas. Readers are encouraged to obtain up-to-date population data online from the Bureau of the Census website.

Finally, my goal for *The Rural Minority Health Resource Book* was to design a readable, user-friendly publication for professionals and students alike, in various health disciplines, to access relevant and current information on rural minorities. In completing this project, I learned a great deal about diversity and various cultures. Hopefully, the material will be informative and useful to the audience as well.

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National Rural Health Association

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RESOURCE BOOK

CHAPTER ONE

OBJECTIVES

After reading this chapter you should be able to:

- Describe demographic trends relating to diversity within the U.S. population.

- Compare and contrast socioeconomic characteristics of the four predominant racial groups in the United States and the impact on health status.

- Collect demographic data and health statistics for populations in your geographical region.

- Discuss the relationships of *Healthy People:2000* and *Healthy People:2010* to the President's Initiative on Eliminating Racial Health Disparities.

- Highlight specific health disparities among racial minorities in the United States.

- Analyze variations in the health status of racial and ethnic minorities living in rural areas compared with those living in urban areas.

- Characterize "cultural-linguistical competence."

- Develop strategies to implement the Standards for Culturally and Linguistically Appropriate Services (CLAS) in clinical practice.

- Describe partnership initiatives among federal, state, and local governments that focus on the health-related needs of rural minorities.

- Compile a list of bibliographic resources related to minorities and the health care delivery system.

DIVERSITY IN AMERICA: PAST, PRESENT, AND FUTURE

OVERVIEW

In this chapter an overview of the U.S. population is presented along with an overview of demographic trends from preliminary Census 2000 reports. Diversity characterizes the U.S. social structure, and the term permeates the popular media and academic literature. Socioeconomic characteristics and health data for the four predominant racial groups will be highlighted. *Healthy People:2010*, the President's Initiative on Eliminating Racial Health Disparities and the Standards for Culturally and Linguistically Appropriate Services (CLAS) will be examined, along with partnership initiatives between federal, state, and local governments that specifically focus on the health issues of minorities in rural areas. The information in this chapter provides the framework for subsequent chapters in this text.

U.S. Population Profile and Trends
www.census.gov

According to preliminary reports from the Census Bureau, Census 2000 shows a racially diverse America. Hispanics (Latinos) are the fastest-growing group, while blacks continue to be the largest minority group but only by a small margin. Amid wide controversy, the process for collecting information for Census 2000 changed from 1990 to better reflect the emerging diversity. This was not the first time categorical revisions were made by the Bureau of Census, however. (Table 1.1) For example, the first U.S. census, held in 1790, classified free residents as "white" or "other"; slaves were counted separately. By 1860, the Census Bureau classified residents as white, black, or quadroon. In 1870, American Indian and Chinese were added as separate categories. In 1890, census-takers distinguished the color of household members as white, black, octoroon (one-eighth black), quadroon (one-quarter black), or as Chinese, Japanese, or American Indian. In 1970, a question was added to collect data on Hispanic origin. Most recently, for Census 2000 respondents could indicate "one or more races" for the first time. This recent change makes direct population-trend comparisons with the 1990 censuses somewhat problematic. For Census 2000, categorical changes were designed to more accurately reflect the nation's racial diversity and its political and social climate. (Table 1.2;

Table 1. 1

RACE CATEGORIES USED BY THE US CENSUS BUREAU: 1900-2000

	1900	1970	2000
RACE	White	White	White
		Negro or Black	Black, African American, or Negro
	Chinese	Chinese	Chinese
	Indian	Indian (Amer.)	American Indian or Alaska Native
	Japanese	Japanese	Japanese
		Filipino	Filipino
			Asian Indian
		Korean	Korean
		Hawaiian	Native Hawaiian
			Vietnamese
			Guamanian or Chamorro
			Samoan
			Other Asian
			Other Pacific Islander
			Other Some other race
HISPANIC		(1971) Mexican	Mexican, Mexican Amer., Chicano
ETHNICITY		Puerto Rican	Puerto Rican
		Central/So. American	
		Cuban	Cuban
		Other Spanish	Other Spanish/Hispanic/Latino
		(None of these)	Not Spanish/Hispanic/Latino

Source: 200 Years of U.S. Census Taking: Population And Housing Questions 1790-1990. U.S. Department of Commerce. U.S. Bureau of the Census.

Table 1.3; Table 1.4) (Figure 1.1; Figure 1.2; Figure 1.3) Figure 1.4 displays a map depicting the distribution of racial minorities in nonmetropolitan areas of the United States. (http://www.schsr.unc.edu/research_programs/Rural_Program/maps/min.html)

According to Census 2000, there are approximately 274.6 million people living in the United States. Of these, approximately 70 million are children, 168 million are working-age adults (18-64), and 35 million are persons over age 65. The U.S. population is mostly white (75.1%) followed by blacks (12.3%), Hispanic (12.5%), Asian and Pacific Islander (3.6%), American Indian (0.9%), and Other (8.1%). Since 1990, about 23 million people have been added to the U.S. population. Hispanics are the fastest-growing racial/ethnic group, adding almost 9 million persons to the population since 1990. (Table 1.5) In brief, the American population will continue to get older and have a longer life expectancy.

Below are a few additional highlights from preliminary reports by the Bureau of Census. (http://www.census.gov/prod/www/abs/briefs.html)

- The three most populous states - California, Texas, and New York – continue to have the highest number of minorities.

- Georgia, Nevada, and North Carolina experienced the biggest percentage increase in population. The influx is attributed to job-related factors and the network of people they know there.

- Nevada's 50% population growth led all other states in the past decade, where the Asian population rose nearly 124% and the Hispanic population (of any race) increased about 145%. Arkansas had the biggest percentage increase among Hispanics: 170.3%.

- California has the largest Hispanic population, with 10.4 million people. More than 2.7 million Hispanics moved into the state between 1990 and 1999 (about 36% increase).

Table 1. 2

U.S. CENSUS 2000: POPULATION MEDIAN AGE BY RACE& AGE *

	MEDIAN AGE (YEARS)	MEAN AGE (YEARS)
ALL RACES	35.8	36.5
WHITE	36.9	37.4
BLACK	30.3	32.3
AMERICAN INDIAN, ESKIMO & ALEUT	27.8	30.6
ASIAN & PACIFIC ISLANDERS	32.0	32.8
HISPANIC (OF ANY RACE)	26.6	9.0

* http://www.census.gov/population/www/estimates/nation3.html

Table 1. 3

PROJECTED U.S. POPULATION GROWTH BY RACE (1995 -2050)*

RACE	1995	2050
WHITE	74%	53%
ASIAN	3%	8%
NATIVE AMERICAN	1%	%
HISPANIC	10%	24%
AFRICAN AMERICAN	12%	14%

* http://www.census.gov/population/www/estimates/nation3.html

Table 1. 4

**PROJECTED LIFE EXPECTANCY AT BIRTH BY
AGE IN YEARS (1995-2050)***

RACE	LIFE EXPECTANCY IN YEARS	
	BORN IN 1995	BORN IN 2050
WHITES	77 YEARS	84 YEARS
HISPANICS	79 YEARS	87 YEARS
AFRICAN-AMERICANS	69 YEARS	74 YEARS
ASIANS	82 YEARS	86 YEARS
NATIVE AMERICANS	76 YEARS	82 YEARS

* *http://www.census.gov/population/www/estimates/nation3.html*

- The number of people over the age of 65 has grown and will continue to increase dramatically as the baby boomers mature. There was a surprising increase in the number of children, too, mostly related to immigration.

- As a group, Hispanics have more single mothers with families (18.3%), followed by blacks (9.4%), whites (7.4%), and Asians (5.1%).

- Demographers project that within 25 years, California, Hawaii, New Mexico, Texas, and perhaps Florida will be "minority majority" states. This means that minorities will make up more than 50% of the population in those states. Some regions of the nation have little racial or ethnic diversity. For example, minorities make up less than 5% of the populations of Maine, New Hampshire, Vermont, and West Virginia. The nation's changing demographic profile has important economic and social implications and definitely will impact the health care delivery system.

Immigration is transforming the U.S. Asian and Hispanic populations. For example, Spanish-speaking people from Guatemala, El Salvador, Ecuador, Central America, and South America are creating communities alongside well-established Mexican, Puerto Rican, and Cuban communities. (Chapter 6) Likewise, until recently the U.S. Asian population was predominantly made up of Japanese, Filipino, and Chinese. In 2000, Asian Americans with ethnic roots in India, Vietnam, or Korea outnumber Japanese Americans. (Chapter 5)

Socioeconomically, minorities are quite diverse, too. For example, the number of minorities in the highest income brackets has more than doubled since 1980. Yet, minorities still account for a disproportionate share of the poor in the United States. More minorities are being elected to public office but they are more likely than non-Hispanic whites to serve time in prison. A greater number of minorities are earning graduate and professional degrees, yet a disproportionately large percentage never finishes high school.

The growth of the African American, Hispanic, Asian, and American Indian populations is profoundly changing the racial and ethnic makeup of schools, workplaces, and neighborhoods. In turn, this demographic shift is creating a new multiracial and multicultural heritage in the United States. Businesses also are marketing products to the expanding minority community. Aspects of African American, Native American /Alaskan Native, Asian and Pacific Islander, and Hispanic/Latino culture – including art, food, music, attire styles – are permeating American society.

Trends in U.S. Health Care Delivery

Health care providers also must respond and become proactive in responding to the health care needs and expectations of diverse populations (clients/patients). Coupled with diversity and increased numbers of immigrants, there are a number of other factors that are driving changes in the U.S. health care delivery system.

Figure 1. 4

PERCENT MINORITY POPULATION, 1990
Nonmetropolitan Counties
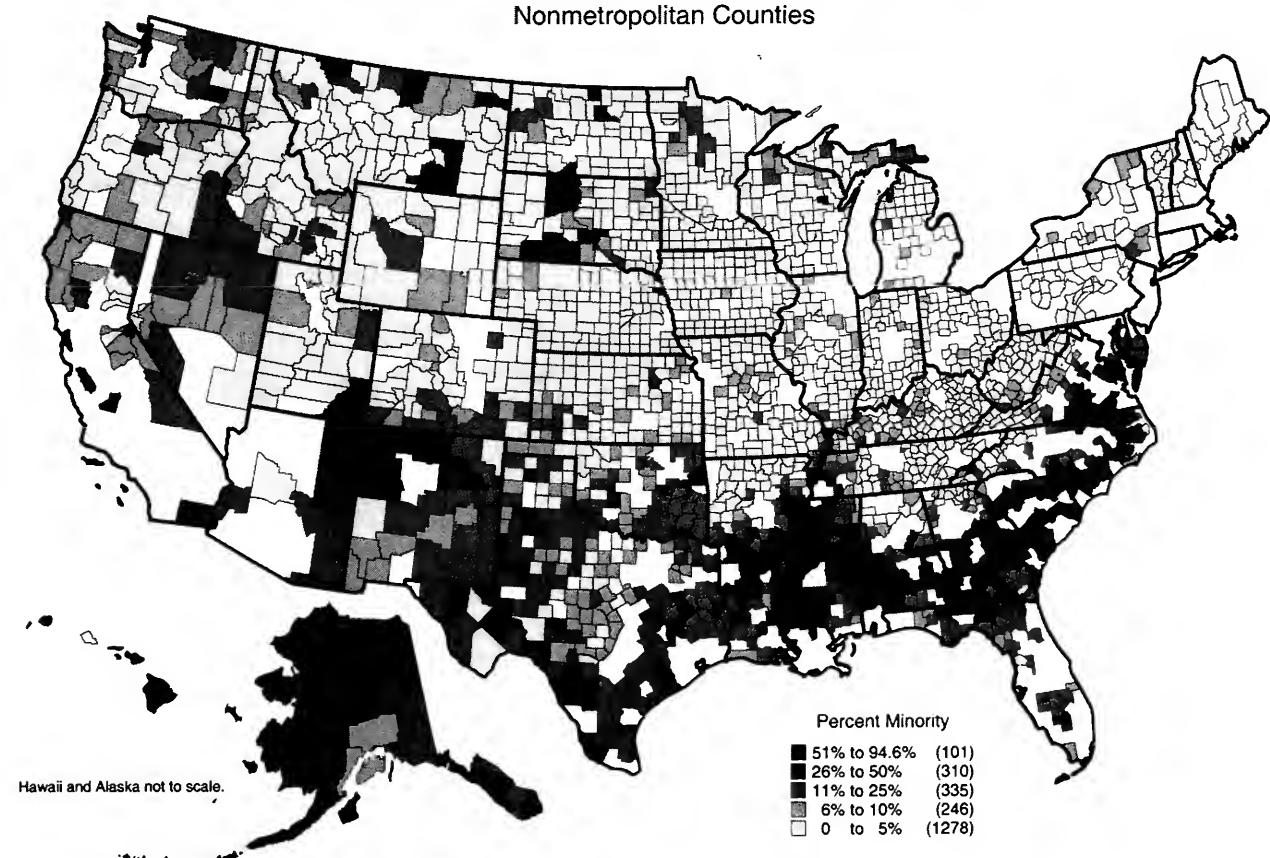
Hawaii and Alaska not to scale.

Percent Minority

■	51% to 94.6%	(101)
■	26% to 50%	(310)
■	11% to 25%	(335)
▨	6% to 10%	(246)
☐	0 to 5%	(1278)

Note: Metropolitan counties are aggregated into white areas on the map.

Source: US Bureau of Census, 1990; revised June 9, 1998.

Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS

Table 1. 5

U.S. CENSUS 2000: POPULATION BY RACE AND HISPANIC OR LATINO ORIGIN, FOR ALL AGES*

TOTAL POPULATION   282,421,906   100.0%

OF THE 274.6 MILLION PEOPLE WHO REPORTED ONLY ONE RACE (NOTE – 6.8 MILLION PEOPLE [2.4%] REPORTED MORE THAN ONE RACE):

WHITE	75.1%
BLACK OR AFRICAN AMERICAN	12.3%
AMERICAN INDIAN AND ALASKA NATIVE	0.9%
ASIAN	3.6%
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0.1%
SOME OTHER RACE	5.5%

OF THE 6.8 MILLION PEOPLE (2.4% OF THE TOTAL POPULATION) WHO REPORTED MORE THAN ONE RACE, 93% REPORTED RACES; ABOUT 7% INDICATED THREE OR MORE RACES. THE MOST COMMON COMBINATIONS WERE:

WHITE AND SOME OTHER RACE	32%
WHITE AND AMERICAN INDIAN AND ALASKA NATIVE	16%
WHITE AND ASIAN	NEARLY 13%
WHITE AND BLACK OR AFRICAN AMERICAN	ABOUT 11%

HISPANIC OR LATINO AND RACE

TOTAL POPULATION   281,421,906   100.0%

HISPANIC OR LATINO (OF ANY RACE)	12.5%
NOT HISPANIC OR LATINO	87.5%
ONE RACE	85.8%
WHITE	69.1%
BLACK OR AFRICAN AMERICAN	12.1%
AMERICAN INDIAN AND ALASKA NATIVE	0.7%
ASIAN	3.6%
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0.1%
SOME OTHER RACE ´	0.2%
TWO OR MORE RACES	1.6%

* Source: U.S. Census Bureau – Internet Release date: April 2, 2001
http://factfinder.census.gov/home/en/datanotes/expplu.html

- Consumers and policy makers alike are concerned about having access to care, controlling costs, and maintaining quality care/services.

- The emphasis on acute in-patient care is shifting to community-based disease prevention and health promotion programs/services.

- The health care sector is a vital part of the local economy, especially in rural communities. The rural health care infrastructure, however, is at grave risk, and this has broad ramifications for sustaining local economies in these communities.

- Some of the most hazardous industries are in rural areas, specifically, fishing, agriculture, forestry, and mining. In turn, this impacts the kinds of health care services that are needed by residents in the community.

- Immigrants, especially those who are very poor and illiterate, are settling in greater numbers in remote and rural areas of the nation. Many of them have very low literacy skills and do not speak or read the English language.

- Individuals and families of minority origins with limited resources are at higher risk for inadequate access to health care. A high proportion of these individuals are either uninsured or underinsured, posing additional risks to their health along with limited access to even basic health care.

In brief, the expanding diversity in the United States mandates that health care services and providers be culturally and linguistically competent to fit with consumers' (clients/patients/communities) needs and expectations.

Healthy People: 2010
http://www.health.gov/healthypeople

Healthy People: 2010 provides a map for improving the health of all Americans during the first decade of the 21st century. Published by the U.S. Department of Health and Human Services (DHHS), the document serves as a valuable guide for health planners in promoting health and preventing illness, disability, and premature death. *Healthy People: 2010* has two overarching goals: increase the quality and years of healthy life and eliminate health disparities. Created by a broad coalition of more than 350 organizations, advocates, and experts from many sectors, the document was designed to measure progress over time. It lists more than 400 objectives to bring better health to all people in this country. Most states and many local governments use the *Healthy People:2010* framework to guide their health policies and programs. (Box 1.2; 1.3)

Healthy People:2010 builds on initiatives of the past two decades. Specifically, in 1979, *Healthy People: The Surgeon General's Report* set national goals for reducing premature deaths and preserving independence for older adults. In 1990, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* identified health improvement goals and objectives to be reached by the year 2000. *Healthy People:2010* continues this tradition and lists 467 specific health objectives within 28 focus areas and is the first to include vision and hearing objectives. This document is designed to guide practitioners,

Box 1. 2

Healthy People: 2010 FOCUS AREAS

1. ACCESS TO QUALITY HEALTH SERVICES
2. ARTHRITIS, OSTEOPOROSIS AND CHRONIC BACK CONDITIONS
3. CANCER
4. CHRONIC KIDNEY DISEASE
5. DIABETES
6. DISABILITY AND SECONDARY CONDITIONS
7. EDUCATIONAL AND COMMUNITY-BASED PROGRAMS
8. ENVIRONMENTAL HEALTH
9. FAMILY PLANNING AND SEXUAL HEALTH
10. FOOD SAFETY
11. HEALTH COMMUNICATION
12. HEART DISEASE AND STROKE
13. HIV
14. IMMUNIZATIONS AND INFECTIOUS DISEASES
15. INJURY AND VIOLENCE PREVENTION
16. MATERNAL, INFANT, AND CHILD HEALTH
17. MEDICAL PRODUCT SAFETY
18. MENTAL HEALTH AND MENTAL DISORDERS
19. NUTRITION
20. OCCUPATIONAL SAFETY AND HEALTH
21. ORAL HEALTH
22. PHYSICAL ACTIVITY AND FITNESS
23. PUBLIC HEALTH INFRASTRUCTURE
24. RESPIRATORY DISEASES
25. SEXUALLY TRANSMITTED DISEASES
26. SUBSTANCE ABUSE
27. TOBACCO USE
28. VISION AND HEARING

http://www.health.gov/healthypeople/Document/default.htm

researchers, and policymakers in addressing existing and emerging health issues, reversing unfavorable trends, and expanding past achievements in the nation's health. Individuals are encouraged to make healthy lifestyle choices; clinicians are challenged to include prevention into their practices. Likewise, communities and businesses are required to support health-promoting policies in schools, work sites, and other community settings. Scientists are invited to pursue new research, using both traditional and innovative approaches, to achieve the 10-year target goals put forth in *Healthy People: 2010*. *Healthy People: 2010* can be used by communities to become healthier places to live.

(Box 1.5)

(www.health.gov/healthypeople/Publications/HealthyCommunities2001/default.htm)

For example, the *Healthy People in Healthy Communities Initiative* can:

- keep community (coalition) members interested and motivated because they will see real changes in the community that result from their actions;

- generate interest from those who have had reservations about or lacked awareness of individual/community efforts; and

- demonstrate to those who fund such efforts that the initiative is working to improve the community.

Box 1. 3

Healthy People: 2010 – PROCESS FOR BUILDING HEALTHIER COMMUNITIES

	WHAT	**HOW**
STEP 1	Decide on an issue your community wants to focus on.	Talk to your neighbors and friends about what is important to them. Get information about community health problems from local/state/federal agencies
STEP 2	Obtain a copy of *Healthy People: 2010* . Identify objectives that relate to community issue/health risk	Contact health department or library to obtain documents or download document(s) from www.health.gov/healthypeople
STEP 3	Use the objectives in *Healthy People:2010* to set goals for community efforts	Pick objectives/information based on your group's understanding of the conditions in neighborhood or community. Seek consultation from local health department.
STEP 4	Design an action plan based on the objectives that you have chosen	Design programs, policies and activities that will help to make improvements in the health of the community.

A number of resources are available from various federal and state agencies to help providers and communities plan *Healthy People: 2010* activities. For example, the *Healthy People Toolkit,* developed with guidance from the DHHS Office of Disease Prevention and Health Promotion and the Public Health Foundation, includes processes, tools, and resources to help a state or community build on past successes and develop 2010 objectives. (www.health.gov/healthypeople/state/toolkit) Another useful tool, *The Healthy Vision Toolkit*, builds on the *Healthy People Toolkit*, provides practical ways to incorporate vision activities, and includes camera-ready art for written materials and promotional materials, vision resources, assessment, and data collection tools. (www.healthyvision20l0.org)

Health Disparities and Race
http://www.cdc.gov/nchs/hphome.htm

The National Center for Health Statistics, using *Healthy People: 2000* indicators, reports notable progress in some areas in the overall health of our nation's people.

However, there continue to be disparities in the burdens of illness and the incidence of death experienced among racial and ethnic minorities, specifically, blacks, Hispanics, American Indians and Alaska Natives, and Asians and Pacific Islanders. Advances in biotechnology and increased access to care only partially address the controversial issues surrounding racial and ethnic health disparities. (http://raceandhealth.hhs.gov)

Box 1. 4

> ### RACIAL HEALTH DISPARITIES INITIATIVE: FOCUS AREAS
> - Infant mortality
> - Cancer screening and management
> - Cardiovascular disease
> - Diabetes
> - HIV infections/AIDS
> - Immunizations
>
> *http://raceandhealth.hhs.gov*

In 1998, President Bill Clinton committed the nation to an ambitious goal by the year 2010: "Eliminate the disparities experienced by racial and ethnic minority populations." Subsequently, the Office of Minority Health (OMH) identified six areas for which racial and ethnic minorities experience serious disparities in health outcomes across the life span. (Box 1.4.) Examples of representative near-term goals for each disparity are cited in Box 1.5. Subsequently, the National Rural Health Association became actively involved with the health care issues of minorities in rural settings and developed the first in a series of issue papers focusing on minorities: *A National Agenda for Rural Minority Health* (May 1999). (See Appendix A)

There are different challenges for each disparity. For some, such as immunizations, more is known about what can be done to eliminate the disparities. For others the knowledge base is less well developed. Overall, health data specific to racial minorities in rural settings is sparse; if it exists it often is incomplete or conflicting. This deficit

Box 1. 5

EXEMPLAR: NEAR TERM GOALS FOR
HEALTH DISPARITIES INITIATIVE*

INFANT MORTALITY

- Reduce infant mortality among blacks by at least 22%.
- Reduce infant mortality rates among American Indian and Alaska Natives and Puerto Ricans, whose rates also are above the national average.
- Continue to monitor progress in reducing the SIDS rates for all racial and ethnic groups.

CANCER SCREENING AND MANAGEMENT

- Increase to at least 60% those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and mammogram within the preceding two years.

  BREAST CANCER

- The goal for the year 2000 for breast cancer screening is to increase to at least 60% those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and a mammogram within the preceding two years.

  CERVICAL CANCER

- The goal for the year 2000 for cervical cancer is to increase to at least 85% the proportion of all women aged 18 and older who have received a Pap test within the preceding three years.

CARDIOVASCULAR DISEASE

- Reduce the heart disease mortality rate among blacks by 25%.
- Reduce the stroke mortality rate among blacks by 40%.

Diabetes

- Reduce the rate of ESRD from diabetes among blacks and American-Indian/Alaska Natives by 65%.
- Reduce lower extremity amputation rates from diabetes among blacks by 40%.

HIV INFECTION/AIDS

- Ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75% of low-income persons living with HIV/AIDS.

IMMUNIZATIONS

  CHILDREN

- Achieve and maintain at least 90% coverage for all recommended childhood vaccines in all populations

  ADULTS

- Increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60%

* Source http://raceandhealth.hhs.gov

resulted in the development of the second issue paper by the National Rural Health Association: *The Need for Standardized Data and Information Systems* (April 2001). (See Appendix B) Each of the six disparities will be briefly examined in the next section. (http://raceandhealth.hhs.gov/sidebars/sbresRW.htm)

Eliminate disparities in infant mortality rates
http://raceandhealth.hhs.gov/2ndpgBlue/2pgInfant.htm

Infant mortality is an important measure of a nation's health and a worldwide indicator of health status. Over the past several decades infant mortality in the United States declined steadily to a record low of 7.2 per 1,000 live births (1996). Yet compared with other industrialized nations the United States still ranks 24th in infant mortality. Infant mortality rates vary substantially among and within racial and ethnic groups. More specifically, infant death rates among blacks, American Indians, Alaska Natives, and Hispanics continue to be above the national average. The greatest disparity is among blacks (14.2 per 1,000 live births), more than twice that of white infants (6.0 per 1,000 live births).

The American Indian infant mortality rates are somewhat lower (9.0 per 1,000 live births). However, this rate does not accurately reflect the diversity among Indian communities. Some tribes experience twice the national infant mortality rates. Similarly, the overall Hispanic infant mortality rate (7.6 per 1,000 live births) does not reflect the racial, ethnic, and cultural diversity within this group. To reduce infant mortality and morbidity among racial and ethnic minorities the focus must be on modifying lifestyle behaviors and socioeconomic factors that affect birth outcomes, such as smoking, use of alcohol and other chemical substances, poor nutrition, psychosocial problems (e.g., stress, domestic violence, poverty), and inadequate prenatal care.

For example, we know that women who receive prenatal care in the first trimester have better pregnancy outcomes than counterparts who receive little or no prenatal care. In fact, the likelihood of delivering a very low birth-weight infant (less than 1,500 grams or 3 lb. 4 oz.) is 40% higher among women who receive late or no prenatal care compared with women entering prenatal care in the first trimester. Approximately 95% of very low birth-weight infants are born preterm (less than 37 weeks gestation).

The risk of early death for very low birth weight infants is about 65 times greater compared to infants who weigh at least 1,500 grams. Over the past decade, the proportion of pregnant women across the nation receiving prenatal care in the first trimester reached nearly 82% in 1996 compared to about 76 % in 1998. Still, one in five pregnant women does not receive timely prenatal care, and about 47,000 women received no prenatal care at all.

Substantial racial disparities exist in the timely receipt of prenatal care. Specifically, in 1996, more white pregnant women (84%) received prenatal care than did black and Hispanic (of all races) pregnant women (71%). Leading causes of death in infants is greatest in the following areas:

- disorders relating to short gestation (preterm birth) and unspecified low birth weight;

- respiratory distress syndrome;

- infections specific to the perinatal period and newborns affected by maternal complications of pregnancy; and

- sudden infant death syndrome (SIDS).

A higher incidence of preterm births occurs among black mothers (17.7%) than among white mothers (9.7%). Underlying factors such as chronic hypertension and bacterial vaginitis (of which there are higher incidences among blacks) play a role in preterm birth and sudden infant death syndrome (SIDS). These conditions account for approximately 10% of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS. Compared to those of whites, SIDS rates are three to four times higher for some American Indian and Alaska Native populations. Racial and ethnic differences in preterm births and SIDS most likely reflect prevalence of risk factors, including socioeconomic and demographic factors, certain medical conditions, quality of and access to health care, and practices such as placing babies on their backs to sleep. Even though there has been some progress in improving perinatal outcomes among racial and ethnic minorities, much remains to be done to address this disparity.

Eliminate disparities in cancer screening and management
http://raceandhealth.hhs.gov/2ndpgBlue/2pgCancer.htm

Cancer is the second leading cause of death in the United States, accounting for more than 544,000 deaths each year. Approximately 7.4 million Americans have or have had cancer. The chances of developing cancer in a lifetime are slightly higher for men (50%) than women (40%) About half of those who develop the disease will die from it. Minority groups suffer disproportionately from cancer and disparities in both mortality and incidence rates. For example:

- For men and women combined, blacks have a cancer death rate about 35% higher (171.6 per 100,000) than whites (127.0 per 100,000).

- The death rate for cancer is about 50% higher in black men (226.8 per 100,000) than in white men (151.8 per 100,000).

- The death rate for lung cancer is about 27% higher for blacks (49.9 per 100,000) than whites (39.3 per 100,000).

- The prostate cancer mortality rate for black men (55.5 per 100,000) is more than twice that for white men (23.8 per 100,000).

- The incidence rate for lung cancer is about 50% higher in black men (110.7 per 100,000) than in white men (72.6 per 100,000).

- Native Hawaiian men have elevated rates of lung cancer compared to white counterparts.

- Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do whites.

- Vietnamese women in the United States have a cervical cancer incidence rate (47.3 per 100,000) five times greater than that of white women (8.7 per 100,000).

- Hispanic women of all races experience increased rates of cervical cancer compared to non-Hispanic white women.

Prevention efforts and modified lifestyles can greatly reduce one's risk for developing cancer. For example, tobacco use is responsible for nearly one-third of all cancer deaths, while diet and nutrition may be related to 30% to 40% of cancer deaths. Each year there are an estimated 900,000 new diagnosed cases of skin cancer, many of which could be prevented by reducing sun exposure. Some cancers cannot be prevented, but early detection can dramatically reduce the risk of death. For women 50 years of age and older, regular mammography screening and appropriate follow-up, for instance, can reduce deaths from breast cancer by about 30%. Likewise, screening by Pap test for cervical cancer along with appropriate follow-up care can virtually eliminate the risk of developing this disease.

Despite the considerable gains in screening within the black community, the mortality rate from breast cancer for black women is greater than for white women. A number of factors are attributed to this racial disparity. For example, many black women never have had a mammogram or a Pap smear. Some are not screened on a regular bases. Others have regular screens but have limited follow-up and treatment services available to them. Overall, Hispanic, American Indian and Alaska Native, and Asian and Pacific Islander women have low(er) rates of screening and treatment, limited access to health facilities and physicians coupled with barriers associated with language, culture, and negative provider attitudes. Little is known about illness prevention behavior for other types of cancers by race. For example, colorectal cancer screening and prostate screening are recommended, yet few data are available on screening rates by race. Incomplete data, along with the lack of culturally and linguistically competent services contribute to racial minorities' having higher morbidity and mortality rates associated with cancer.

Eliminate disparities in cardiovascular disease
http://raceandhealth.hhs.gov/2ndpgBlue/2pgCardio.htm

Cardiovascular disease, primarily coronary heart disease and stroke, kills nearly as many Americans as all other diseases combined. Nationally, the annual economic impact of cardiovascular disease is estimated to be $259 billion as measured in health care expenditures, medications, and lost productivity associated with disability and death. The impact of premature morbidity from cardiovascular disease on the ability of affected individuals to function independently or to participate fully in everyday life is devastating in terms of personal loss, pain, suffering, and effects on families and loved ones. Risk factors for cardiovascular disease include high blood pressure, high blood cholesterol, cigarette smoking, excessive body weight, and physical inactivity. The greatest potential

for reducing coronary heart disease morbidity, disability, and mortality lies in prevention and by modifying these risk factors.

Compared with those having a normal blood pressure, persons with high blood pressure have three to four times the risk of developing coronary heart disease and seven times the risk of having a stroke. Blood pressure reduction, for instance, significantly reduces stroke mortality and can reduce deaths from coronary heart disease. There also is a substantial reduction in coronary heart disease rates following smoking cessation, maintaining an appropriate body mass (versus being overweight) and being physically active (versus being sedentary). Cardiovascular disease is the leading cause of death for all groups but there is a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. From 1987 to 1995, the age-adjusted death rate for coronary heart disease for the total population declined by 20%, but among blacks it decreased only 13%. Compared with that of whites, coronary heart disease mortality was lower for some Asian American groups but significantly higher for blacks.

Disparities exist in the prevalence of risk factors for cardiovascular disease, too. Racial minorities have higher rates of hypertension, develop it at an earlier age and are less likely to undergo treatment to control their high blood pressure. From 1988 to 1994, a higher proportion of black males ages 20 to 74 (35%) had hypertension compared to all men (25%).When age differences are taken into account, Mexican-American men and women also have elevated blood pressure rates. Among adult women, the age-adjusted prevalence of overweight continues to be higher for black women (53%) and Mexican-American women (52%) than for white women (34%). There also are racial disparities in regular screening for cholesterol; for example, about half of American Indians/Alaska Natives (50%), and even fewer Asian Americans (44%), and Mexican-Americans (38%) have had their cholesterol checked within the past two years. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke.

Eliminate disparities in diabetes
http://raceandhealth.hhs.gov/2ndpgBlue/2pgDiab.htm

Diabetes is the seventh-leading cause of death, affecting 16 million Americans, and Type II Diabetes has become a major public health concern in the United States. Nationally, the estimated direct and indirect cost of diabetes is more than $98 billion. The prevalence of diabetes in blacks is 70% higher than in whites; the prevalence in Hispanics of all races is nearly double that of non-Hispanic whites. The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for the total population. At least one tribe, the Pimas of Arizona, has the highest known prevalence of diabetes of any population in the world. Individuals with diabetes face the probability of a shortened life span along with multiple acute and chronic complications, including end-stage renal disease, blindness, and lower extremity amputations. Cardiovascular disease

is the leading cause of death among people with diabetes and accounts for more than half of all deaths.

Many diabetes-related complications could be prevented. For example, among diabetics if uncontrolled hypertension were reduced by half, about one-quarter of end-stage renal disease resulting from diabetes could be prevented. Diabetic retinopathy is the leading cause of new cases of blindness among people 20 to 44 years of age. Approximately 60% of diabetes-related blindness can be prevented with good blood glucose control, early detection and laser photo coagulation treatment (widely available but underused). One half of all lower-extremity amputations could be prevented through proper foot care and by reducing risk factors such as hyperglycemia (abnormally high blood sugar), cigarette smoking, and high blood pressure.

Preventive interventions should focus on high-risk groups, specifically African Americans and Native Americans. Rates for diabetes-related complications, such as end-stage renal disease and amputations, are higher among blacks and American Indians compared to the total population. Even among similarly insured populations, blacks are more likely than whites to be hospitalized for septicemia, debridement, and amputations. These conditions are associated with poor diabetic control. A greater proportion of minorities develop Type 2 (non-insulin-dependent) diabetes in adolescence; thus, they contend with a lifetime of diabetes and its potential complications. Undiagnosed and poorly controlled diabetes increases the likelihood of serious complications. More precisely, for every two people who are aware of their illness, one person remains undiagnosed. The increasing burden of diabetes is alarming, but often it can be prevented with early detection, improved care, and self-management education. The challenge is to make proper diabetes management part of daily clinical and public health practice.

Eliminate disparities in HIV Infection/AIDS
http://raceandhealth.hhs.gov/2ndpgBlue/2pgHIV.htm

AIDS (HIV/AIDS) is a leading cause of death for all persons 25 to 44 years of age. Between 650,000 and 900,000 Americans are estimated to be infected with HIV, and 375,000 have died from the disease. HIV/AIDS disproportionately affects minorities. According to the Centers for Disease Control, racial minorities constitute approximately 25% of the total U.S. population (Figure 1.4), yet they account for more than half of all new AIDS cases. (Box 1.6)

Currently, in the United States, several epidemics are occurring simultaneously. In 1989, the number of AIDS diagnoses among gay and bisexual men decreased dramatically among white men, but the number of AIDS cases among black men who have sex with men has increased. New infections related to intravenous drug use increasingly are concentrated in minorities (75%), specifically in blacks (56%) and Hispanics of all races (20%). Of cases reported among women and children, more than 75% are among racial and ethnic minorities. From 1995 and 1996, AIDS-related death rates declined more for the total U.S. population (23%) compared to blacks (13%) and Hispanics of all races (20%). Contributing factors for the disparities in HIV/AIDS include late identification of

Box 1. 6

FACTS ABOUT HIV/AIDS & MINORITY YOUTH

- African American and Hispanic/Latino teens, ages 13-19, each represent approximately 15% of all U.S. teens. Yet, African American teens account for 60% and Hispanic/Latino teens account for 24% of all new AIDS cases.

- African American women ages 13-19 represent 15% of all U.S. young women but account for 66% of all AIDS cases reported among young women.

- Among young men who have sex with men, ages 15-22 in six urban counties, a higher percentage of African Americans (13%) and Hispanics (5%) than whites (4%) are infected with HIV.

- Compared to white teens, African American teens are more than twice as likely and Hispanic/Latino teens are one and a half times as likely to say they are very concerned about becoming infected.

- More than one in four African American teens, and one in five Hispanic/Latino teens say they know someone who has AIDS, has died from AIDS, or has tested positive for HIV.

Sources: Centers for Disease Control www.cdc.gov.hiv/dhap.htm
Kaiser Family Foundation, National Survey of Teens on HIV/AIDS: 2000 – www.kff.org

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the disease and, once it is diagnosed, lack of health insurance to pay for costly drug therapies. The cost of treating HIV/AIDS in 1999 ranged from $10,000 to $12,000 per-patient per-year. One can say with a high level of certainty, the cost for treating and managing HIV/AIDS has increased dramatically since then (American Academy of HIV Medicine, http://aahivm.org).

About one-third of people who are at risk for HIV/AIDS have never been tested. Likewise, prevention strategies are needed that are acceptable to the target community, in other words, the intervention must be culturally and linguistically appropriate. Prevention efforts have contributed to slowing the spread of HIV, and the declining death rate is attributable to effective antiretroviral therapies. Treatment advances are improving the quality of life for persons living with AIDS (PLWA) but not everyone is benefiting equally. Among minorities, there is a need for education about knowing one's serostatus, improved access to counseling, testing, specialty services and efficacious therapies to prevent HIV transmission and improve the quality of life for PLWA, along with economic factors, inadequate recognition of risk, detection of infection, and referral to follow-up care are major issues for high-risk populations.

Box 1. 1

TERMS AND DEFINITIONS

asylum-seeker
      person coming to the U.S. applying for refugee status

immigrant
      a nonresident (alien) admitted for permanent residence

refugee
      person admitted outside normal quota restrictions based on a well-founded fear of persecution because of race, religion, nationality, social or political opinion; generally they do not willingly choose to come to the U.S. but do so under dire circumstances

Culture
      integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. *

Competence
      implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. *

Cultural and linguistic competence
      set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross cultural situations. *

documented worker
      individual who possesses necessary documents to legally reside or work ("green card") in the U.S.

undocumented worker ("illegal aliens")
      individual not possessing the necessary document to legally reside or work ("green card") in the U.S.

Census Bureau race/category descriptors http://www.census.gov/prod/www

White (race/category)
      Caucasian/Anglo-American/ white non-Hispanic; persons having origins in Europe; sometimes referred to as "main stream American"

Black (race/category)
      African American/Negro/Afro-American; persons having origins in Africa

American Indian (race/category)
      American Indian/Native American & Alaska Native; people having indigenous origins in North and South America (including Central America) and who maintain tribal affiliation/community attachment

Asian (race/category)
      Asian Americans; persons having origins in the Far East, Southeast Asia, or the Indian subcontinent, includes Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese; Burmese, Hmong, Pakistani, Thai, Laotian and other ethnic groups

Native Hawaiian/Pacific Islander (race/category)
            persons having indigenous origins in Hawaii, Guam, Samoa, or other Pacific islands

Hispanic (race/category)
      Of Latino background; may be of any race; sub-classified by the Bureau of the Census into "all Hispanics" and "non-Hispanic whites"

Eliminate disparities in child and adult immunization rates
http://raceandhealth.hhs.gov/2ndpgBlue/2pgImmu.htm

The reduction in incidence of vaccine-preventable diseases is one of the most significant public health achievements of the past 100 years. Success is evidenced by the global eradication of smallpox in 1977 and the projected eradication of polio in foreseeable future. Annually, billions of dollars are saved through the use of vaccines. Nationally, childhood immunization rates are at an all-time high (90%). In fact, immunization targets specified in *Healthy People: 2000* for all five essential vaccines were exceeded (measles, mumps, and rubella [MMR]; polio; diphtheria, tetanus, and pertussis [DTP]; Haemophilus influenza type B [Hib]; and hepatitis B [Hep B]).

Immunization rates have been lower in minority populations compared with the white population. However, complete immunization rates increased among minorities at a more rapid rate, thus significantly narrowing the gap. Overall coverage for preschool immunization is high. There continue to be pockets within each state and within major cities where there are substantial numbers of underimmunized children. This disparity is of particular concern among underserved populations, where there is a potential for outbreaks of vaccine-preventable diseases.

Older adults are at increased risk for many vaccine-preventable diseases. Nationally, of all influenza-associated deaths, 90% occur in those who are 65 years and older (the fastest-growing age group of the total population). Partly reduction of deaths in this age group is hindered by relatively low vaccine utilization. Annually, about 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of vaccines to prevent these conditions and their complications. The overall cost to society for vaccine-preventable diseases exceeds $10 billion each year. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the general population and targets set forth in *Healthy People: 2000*. In other words, there continues to be a disproportionate burden of vaccine preventable diseases in minority and underserved populations. Current efforts must be sustained in order to achieve and maintain at least 90% coverage for all recommended vaccines in all populations.

Health Insurance Coverage Patterns

Recently, the University of California Los Angeles (UCLA) Center for Health Policy Research (www.healthpolicy.ucla.edu/publications) and the Henry J. Kaiser Family Foundation (www.kff.org) published demographic information about coverage under public and private health insurance programs and access to care patterns (e.g., by citizenship, education levels, work status and race).

The majority of the nation's 44 million uninsured are white, but minorities are disproportionately affected by the lack of health insurance and less likely to have job-based health insurance coverage. More specifically, Latinos have the highest uninsured rate

(about 37%) followed by African Americans (about 25%), Asian Americans and Pacific Islanders (about 20%), and non Hispanic whites (14%). Uninsured rates are lower among Native Americans (17%) largely due to their ability to receive services through Indian Health Service (IHS). (Additional details about the IHS are presented in Chapter 4.)

Minorities made gains of 3% to 4% in job-based coverage between 1994 and 1997 due to a strong economy but gains were offset for most groups by declines in Medicaid coverage. In turn, policy changes associated with the welfare-to-work legislation contributed to the growth in the number of uninsured people in the U.S. Medicaid is an important health insurance safety net for many low-income people. Due to their lower incomes, African Americans, Latinos and Native Americans are about three times as likely to participate in the Medicaid program as whites.

Minorities also have less access to care compared to non-Hispanic whites. Differences in access to care have been measured on (a) the extent to which individuals do not have a regular person or place where they receive care and (b) the frequency of physician visits. Using these two criteria, Latino and Asian American/Pacific Islander adults are about one and a half times as likely as white adults not to have a usual source of health care.

Minority children experience higher uninsured rates than do white children. Hispanic/Latino, Asian American/Pacific Islander, and Native American children are two to three times more likely than white children to not have a usual source of care. Among adults in fair or poor health, minorities are less likely than white adults to have seen a physician even once in the past year. Children, although generally healthier, need visits to a regular provider for prevention services and developmental evaluation. Minority children are less likely than white children to have seen a physician recently. In comparison, fewer white school-age children (7%) did not have a doctor's visit in the past two years than did Native American children (18%), Latino children (16%), and Asian American/Pacific Islander children (12%) who did not have such a visit. For many minorities, lack of health insurance creates a barrier to accessing basic health care and exacerbates chronic conditions such as heart disease, diabetes and cancer by delaying diagnosis and reducing effective management and treatment. These barriers, in turn, reduce use of preventive services such as screening and health education and counseling. The National Rural Health Association developed another issue paper in its rural minority series that focuses on the aforementioned barriers titled *The Need for Responsive Rural Health Delivery Systems* (July 2001). (See Appendix D.)

Needed: Culturally and linguistically competent providers

Increasingly, health providers are treating clients of diverse racial and ethnic origins. Unfortunately, there is not an equitable representation of racial minorities in entering into or practicing in the health professions. In turn, this means there is a need for providers to design and deliver health-related services that fit the cultural and linguistic preferences of consumers. The National Rural Health Association developed another issue paper in its rural minority series that focuses on the education, recruitment and

retention of minority health professionals titled *Recruitment and Training of Health Professionals* (April 2001).(See Appendix C) (Box 1.8)

Culturally and linguistically appropriate care can improve clients' health outcomes as well as their satisfaction with services and providers. There is an assortment of definitions and interpretations of "cultural competency." For example, an external accrediting agency focuses on the importance of providing interpreter services, while a small health care facility devotes resources to incorporate traditional healing with western medicine. Until now, health care organizations have been on their own when it comes to figuring out what cultural competency means.

Standards for Culturally and Linguistically Appropriate Services (CLAS)

Recently the Office of Minority Health (DHHS-OMH) published *Standards for Culturally and Linguistically Appropriate Services* (CLAS) in health care. (Box 1.1; Box 1.7). The document also includes definitions for three diversity-related terms: culture, competency, cultural and linguistic competency. This OMH initiative is expected to reduce confusion as to what constitutes culturally and linguistically competent care among the following audiences.

Policymakers. To draft consistent and comprehensive laws, regulations and contract language. This audience would include federal, state and local legislators, administrative and oversight staff, and program managers.

Accreditation and credentialing agencies. To assess and compare providers who say they provide culturally competent services and to ensure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance, professional organizations such as the American Medical and Nurses associations, and quality review organizations such as Peer Review Organizations.

Purchasers. To advocate for the needs of diverse consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.

Box 1. 8

DISTRIBUTION OF NONFEDERAL PHYSICIANS BY RACE/ETHNICITY, 1999 *

RACE	PERCENT REPRESENTED
White	56.3%
Black	2.8%
Hispanic	3.1%
Asian	9.9%
American Indian/Alaskan Native	0.1%
Other Minority	2.6%
Race/Ethnicity Unknown	24.6%

* Source: State Health Facts Online
  http://www.statehealthfacts.kff.org

Box 1. 7

OMH – CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) STANDARDS *

CULTURALLY COMPETENT CARE (STANDARDS 1-3)

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

LANGUAGE ACCESS SERVICES (STANDARDS 4-7)

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must ensure the competence of language assistance provided to limited English proficiency patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

ORGANIZATIONAL SUPPORTS FOR CULTURAL COMPETENCE (STANDARDS 8-14).

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make information available to the public about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

* Office of Minority Health
www.omhrc.gov/ctg/ctgApril.pdf

Patients/clients. To understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them.

Advocates. To promote quality health care for diverse populations, and to assess and monitor care being delivered by providers. The potential audience is quite wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant and other community-focused organizations; and local and national nonprofit organizations that address health care issues.

Educators. To incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include health care professions educators and training institutions, as well as legal and social services professions educators.

Health care community. To debate and assess their applicability and adoption into standard health care practice.

All level of staff in health care organizations. For continuing education and cultural competency training

Researchers and information managers. To use a variety of methods to collect and use accurate demographic, cultural, and epidemiological data for racial and ethnic groups in the service area; and create accountability systems that ensure high quality services for diverse populations.

Office for Civil Rights (OCR)
http://www.hhs.gov/ocr/index.html

The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (DHHS) enforces federal laws that prohibit discrimination by health care and human service providers that receive funds from the DHHS; specifically;

- Title VI of the Civil Rights Act of 1964

- Section 504 of the Rehabilitation Act of 1973

- Title II of the Americans with Disabilities Act of 1975

- Community Service Assurance provisions of the Hill-Burton Act

- Language Assistance to Persons with Limited English Proficiency (LEP)

Federal laws prohibit discrimination in such programs based on race, disability, color, age, religion, national origin, and sex. Institutions, programs and services that may receive funds from the DHHS include:

- Hospitals

- Medicaid and Medicare

- Adoption agencies

- Physicians and other health care professionals in private practice with patients assisted by Medicaid

- Family health centers

- Community mental health centers

- Alcohol and drug treatment centers

- Nursing homes/extended care facilities

- State agencies that are responsible for administering health care

- Foster care homes

- Day care centers

- Senior citizen centers

- Nutrition programs

- Public assistance programs

- State and local income assistance and human service agencies

The Office for Civil Rights (OCR) enforces requirements for the aforementioned legislation through procedures provided for in Title VI regulations. If someone believes she has been discriminated against – because of race, color, national origin, disability, age, and in some cases sex or religion – by an entity (recipient) receiving financial assistance from the DHHS, the individual or her representative may file a complaint with OCR.

(www.hhs.gov/ocr/howtofile.html) Complaints must be filed within 180 days of the alleged discriminatory act. The OCR may extend the 180-day deadline if one can show "good cause." Include the following information in your written complaint or obtain a Discrimination Complaint Form from OCR.

- Name, address and telephone number of person preparing the complaint. You must sign your name; if filed on someone's behalf, include your name, address, telephone number and statement of your relationship to that person (e.g., spouse, attorney, friend, son/daughter).

- Name and address of the institution or agency you believe discriminated against you.

- How, why and when you believe you were discriminated against.

- Any other relevant information.

Send the complaint to the regional manager at the appropriate OCR regional office or to the OCR Headquarters (USDHHS, 2000)

All of these pieces of legislation apply to rural and urban settings alike, but not all of them can be discussed due to space constraints. A few comments will be made about the Hill-Burton Act and the Language Assistance to Persons with Limited English Proficiency (LEP) since these sometimes present special challenges to small rural health care facilities.

The Hill-Burton Act Service Obligation
http://www.hhs.gov/ocr/hburton.html

The Hill-Burton Act authorizes assistance to public and other nonprofit medical facilities. Community Service Assurance under Title VI of the Public Health Service Act requires each recipient of these funds to make services provided by the facility available to persons residing in its service area without discrimination on the basis of race, color, national origin, creed or any other ground unrelated to the individual's need for the service or the availability of the needed service in the facility. These requirements also apply to persons employed in the service area of the facility if it was funded under Title XVI of the Public Health Service Act. There are several basic requirements that every Hill-Burton hospital/facility must comply with to fulfill the community service responsibility.

- A person residing in the Hill-Burton facility's service area has the right to medical treatment at the facility without regard to race, color, national origin, or creed.

- Hill-Burton facilities must participate in Medicare and Medicaid programs unless they are ineligible to participate.

- Hill-Burton facilities must make arrangements for reimbursement for services with principal state and local third-party payers that provide reimbursement that is not less than the actual cost of the services.

- A Hill-Burton facility must post notices informing the public of its community service obligations in English and Spanish. If 10% or more of the households in the serv-

ice area usually speak a language other than English or Spanish, the facility must translate the notice into that language and post it as well.

- A Hill-Burton facility may not deny emergency services to any person residing in the facility's service area on the grounds that the person is unable to pay for those services. (NOTE: Community service obligation is different from the uncompensated care provision. The community service obligation does not require the facility to make non-emergency services available to persons unable to pay for them.)

- A Hill-Burton facility may not adopt patient admission policies that have the effect of excluding persons on grounds of race, color, national origin, creed or any other ground unrelated to the patient's need for the service or the availability of the needed service.

Language Assistance to Persons with Limited English Proficiency (LEP) *http://www.hhs.gov/ocr/lep/*

To ensure that persons with limited English skills can access critical health and social services, the OCR published policy guidance that outlines the responsibilities under federal law of health and social services providers who receive federal assistance from DHHS to assist people with limited English skills. Under Title VI, funding recipients must take steps to ensure that LEP persons can meaningfully access health and social services. A program of language assistance should provide effective communication between the service provider and the LEP person to facilitate participation in and meaningful access to services. (Box 1.7)

Effective communication can be ensured by implementing a comprehensive written language assistance program that includes:

- Policies and procedures for identifying and assessing the language needs of LEP applicants/clients that provide a range of oral language assistance options.

- Notice to LEP persons of the right to language assistance.

- Periodic training of staff, monitoring of the program and, in certain circumstances, translating of the written materials.

Even when written translations are not dictated by need, agencies and providers still must provide oral interpretation of a written document, if necessary, to ensure meaningful access for LEP persons. The option that is selected to communicate with LEP persons will depend on a variety of factors including the frequency of need and size of population(s) being served. Examples of the available options include:

- Hiring bilingual staff for patient/client contact positions.

- Hiring staff interpreters.

- Contracting for interpreter services.

- Engaging community volunteers.

- Contracting with a telephone interpreter service.

Examples of practices that may violate Title VI include:

- Providing services to LEP persons that are more limited in scope or are lower in quality than those provided to other persons.

- Subjecting LEP persons to unreasonable delays in the delivery of services.

- Limiting participation in a program or activity on the basis of English proficiency.

- Failing to inform LEP persons of the right to receive free interpreter services and/or requiring LEP persons to provide their own interpreter.

Partnership Initiatives
http://raceandhealth.hhs.gov/sidebars/sbpart.htm

In the past decade there has been an emphasis at the national level on partnerships, collaborations, and coalitions to address the needs of minorities at the state and local levels. There is no way that each partnership model can be examined within the space allowed for this text. With that in mind, five such initiatives will be highlighted as examples of models that specifically target underserved, rural, and/or minority populations and health care providers, specifically, the Healthy People: Healthy Communities Partnership Initiative, the Area Health Education Center (AHEC) program, Health Education and Training Centers (HETCs) program, the National Health Service Corps (NHSC), and the Children's Health Insurance Program. The reader is encouraged to peruse resources included within the various chapters for additional partnership opportunities.

Healthy People: Healthy Communities Partnership Initiative
www.nnh.org

The U.S. Department of Agriculture (USDA) Cooperative Extension System, in partnership with the Cooperative State Research, Education and Extension Service initiative, focuses on forming community partnerships. The objective is to create innovative entrepreneurial solutions for improving the health care of the community as a whole. Using a community-based planning model, partnerships include other health educators; federal, state and local government agencies; corporations and businesses; professional and civic associations; and health care providers. Health is viewed in the broadest sense, to include physical sciences, economics, social behaviors, politics, environmental sciences, and geography. As a result, maintaining health is the responsibility of all who influence the health and well-being of individuals and communities. While issues of personal health, access to care, and capacity-building for communities are important to all, this initiative targets:

- people with limited resources (rural and urban);

- communities with limited resources;

- farm operators, agriculture and forestry workers and their families;

- health professionals and volunteers (rural and urban); and

- youth, particularly those with limited resources.

This particular initiative promotes capacity-building of individuals, families, and communities to increase healthy behaviors and lifestyle choices and to make informed consumer decisions. It may also strengthen community leadership and promote formation of quality partnerships and infrastructures to meet local health and health care needs. Ultimately, the initiative is designed to bring together the extension, teaching, and research resources of the land-grant university system and its stakeholder to address health care issues.

Area Health Education Centers (AHECs) Program
http://www.hhs.gov

The AHECs Program, created by Congress in 1971, encourages medical schools to increase the number of students and residents who are trained in underserved and community-based settings. Through a combination of federal, state and local funding, medical schools established regional AHECs to foster collaboration between academic health centers and community organizations. Each AHEC is overseen by a local governing or advisory board composed of health professionals, educators, business leaders and a variety of consumer groups. (Box 1.9)

Health Education and Training Centers (HETCs) Program
http://www.hhs.gov

In 1988 the Health Education and Training Centers (HETCs) Program was created. Its mission is similar to that of AHECs, but HETCs target communities with large minority populations, specifically (a) those with severe and persistent shortages of health professionals and (b) increasing programs for health promotion and disease prevention. Approximately half of all HETCs are located along the U.S.-Mexico border and Florida; the remainder are located in other chronically underserved rural and urban communities. Coupled with their focus on health professional shortage areas (HPSAs) and medically underserved (MUS) populations, AHEC and HETC programs:

- develop and support community-based education programs for medical, nursing, pharmacy, allied health, and other students;

- meet continuing education needs for a broad array of health professionals;

- recruit underrepresented and disadvantaged persons into health careers;

- conduct health promotion and disease prevention activities; and

- assist communities in recruiting and retaining health providers.

In addition to the core functions described above, AHECs and HETCs have developed expertise to help communities identify and address current and projected needs. Examples include:

- capacity-building by assisting organizations with strategic and long range planning;

- exploration of alternative strategies for achieving objectives;

Box 1. 9

HISTORY OF LEGISLATION & EVALUATION REPORTS OF AHECs/HETCs

LEGISLATION	EVALUATION REPORTS
1971 Comprehensive Health Manpower Training Act	Carnegie Commission Report on Higher Education and the Nation's Health (1970)
1976 Health Professions Educational Assistance Act	House of Representatives Report by the Committee on Interstate and Foreign Commerce (1975)
1981 Omnibus Budget Reconciliation Act	
	Eleven AHECs: The view from the grass roots (1980)
1985 Health Professions Training Reauthorization Act	AHECs: The pioneering years (1979)
1988 Health Professions Training Assistance Act	
	Report of the Secretary of Health, Education and Welfare on the National AHEC program, (1979)
1992 Health Professions Extension Amendments	
1998 Health Professions and Education Partnerships Act	Report to the Congress of the U.S. by the Comptroller General (1978)
	House of Representatives Report of the Committee on the Budget (1981)

Source:
Federal AHEC Branch
MPH, Branch Chief
Parklawn Building, Room 9-105
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-6950
www.hrsa.dhhs.gov/bhpr/dm/ahecmiss.htm

Evaluation of the impact of the National AHEC program (1990)

AHECs: A role in enhancing the rural practice environment (1995)

- identifying resources and implementing and evaluating programs;
- functioning as "neutral brokers" by convening, facilitating, and promoting coordination and collaboration among multiple organizations; and

- participating in demonstration programs that emphasize education and training through private and public-private partnerships.

Through a comprehensive array of health workforce activities, AHECs and HETCs help to identify, motivate, train, recruit and retain health professionals in underserved communities. Most programs are established with federal "seed money," which leverage a significant amount of state and local matching support.

National Health Service Corps (NHSC)
http://www.bphc.hrsa.dhhs.gov/nhsc

The National Health Service Corps (NHSC) is under the auspices of the Health Resources and Services Administration – Bureau of Primary Health Care. www.bphc.hrsa.gov

Its mission is to increase access to primary care services and reduce health disparities for people in HPSAs/MUAs by assisting communities through site development and by the preparation, recruitment and retention of primary care clinicians. The NHSC, created in 1970, fills a need for primary care clinicians in rural communities and inner-city neighborhoods. Health professional shortage areas (HPSAs) can be found in rural and urban communities. In partnership with these communities, the NHSC combines government and community resources to meet the health care needs of the underserved.

Connecting communities in need to clinicians dedicated to serving them, the NHSC provides primary health care through a culturally competent, team-based approach. In cooperation with regional and state partners, the NHSC offers students and residents opportunities to serve on interdisciplinary teams in underserved areas. The NHSC offers student experiences, mentoring and competitive financial incentive opportunities leading to rewarding careers. The NHSC scholarship program helps finance education for future primary care providers who are committed to serving the underserved. NHSC's loan repayment program is for clinicians with qualified educational loans who choose to serve at an eligible site. The NHSC provides matching funds directly to states to operate their own loan repayment programs. Program details vary from state to state. In sum, NHSC clinicians benefit from a rewarding professional life and play an important role in making care more accessible to the medically underserved.

(State) Children's Health Insurance Program (S)CHIP
http://www.hcfa.gov/init/children.htm

The Children's Health Insurance Program (CHIP), created in 1997 as part of the Federal Balanced Budget Act (State Children's Health Insurance Program," Title XXI, Social Security Act, 1997, Section 2101[a]) appropriated about $40 billion over the next 10 years for states to provide health insurance to uninsured children. Under this legislation, states may either expand their existing Medicaid programs or develop new health insurance options. Of the estimated 8 to 11 million children who go without health insurance, approximately 4.3 million currently are eligible for existing Medicaid insurance. Many more are eligible under CHIP and other programs sponsored through Blue Cross/Blue Shield in more than 25 states. Effective outreach programs to identify and enroll eligible

children into these programs continues to be a challenge for many states even though there are some federal funds for administrative expenses, particularly children of minorities living in rural areas.

SUMMARY

This chapter highlighted U.S. demographic trends related to increasing diversity within the population. Socioeconomic characteristics and health data were presented for the predominant racial groups. Focus areas of *Healthy People:2010*, the President's Initiative on Eliminating Racial Health Disparities, and the *Standards for Culturally and Linguistically Appropriate Services* (CLAS) were examined. The chapter concluded with a discussion of partnership initiatives between federal, state, and local governments that focus on the health care needs of rural minorities. This information will serve as the foundation for the remaining chapters in this text.

CHAPTER ONE

Discussion Questions

- Locate and analyze the demographic profile of the clientele served by your agency/institution. How do these statistics compare with preliminary reports provided by Census 2000? Your state's demographic profile? (Similarities? Differences? Patterns? Trends?)

- Contact your state and/or local health department to obtain information related to racial and ethnic health disparities based on *Healthy People:2000*. Compare and contrast statistics for rural and urban populations. How is that state responding to these particular health concerns? How is your facility/institution?

- Discuss strategies, then develop a plan to implement CLAS Standards within your clinical unit/institution. Disseminate this plan to the appropriate personnel.

- Identify and collect information about federal-state (local) partnership initiatives focusing on minorities in your community. How do these entities interface with your health care facility?

- Identify and characterize health professional shortage areas in your state/catchment area (i.e., demographic profile, health professional work force needs, access to care issues, economic infrastructures, health care resources). Analyze particular health-related needs/issues confronting minority groups in this community.

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http://www.healthpolicy.ucla.edu/publications

and the Henry J. Kaiser Family Foundation www.kff.org

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American Academy of HIV Medicine
836 N. La Cienega Blvd., Suite 303
Los Angeles, CA 90069-4708
(310) 278-6380
Toll-free (866) 241-9601
http://aahivm.org/new/index.html

American Indian Health Facts
http://www.cdc.gov/nchs/fastats/indfacts.htm

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000
www.ama-assn.org

American Medical Student Association
1902 Association Drive
Reston, VA 20191
(800) 767-2266
www.amsa.org

American Translators Association
225 Reinekers Lane, Suite 590
Alexandria, VA 22314
(703) 683-6100
www.atanet.org

Asian or Pacific Islanders Health Facts
http://www.cdc.gov/nchs/fastats/apifacts.htm

Association of American Medical Colleges
2450 N Street, NW
Washington, DC 20037-1127
(202) 828-0400
www.aamc.org

Association of Clinicians for the Underserved
501 Darby Creek Road, Suite 20
Lexington, KY 40509-1606
(606) 263-0046
www.clinicians.org

Association for Multicultural Counseling and Development
5999 Stevenson Avenue
Alexandria, VA 22304
(800) 347-6647
(703) 823-9800
www.counseling.org

Bureau of Labor Statistics
Labor and economic data about the United States workforce.
www.bls.gov

Bureau of Primary Health Care – Health Resources and Services Administration
4350 East-West Highway
Bethesda, MD 20814
(301) 594-4100
www.bphc.hrsa.gov

Centers for Disease Control and Prevention
CDC – African American Health Facts
http://www.cdc.gov/nchs/fastats/aafacts.htm

CDC – Hispanic American Health Facts
http://www.cdc.gov/nchs/fastats/hisfacts.htm

CDC – American Indian Health Facts
http://www.cdc.gov/nchs/fastats/indfacts.htm

CDC – Asian or Pacific Islanders Health Facts
http://www.cdc.gov/nchs/fastats/apifacts.htm

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Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd.
Baltimore, MD 21244-1850
(410) 786-3000
www.cms.gov

Cross Cultural Health Care Program
Pacific Medical Clinics
1200 12th Ave. South
Seattle, WA 98144
(206) 326-4161
www.xculture.org

Division of Health Professions Diversity
(a unit of HRSA's Bureau of Health Professions)
http://bhpr.hrsa.gov/dhpd/home.htm
Diversity Rx:

Promoting language and cultural competence for minority, immigrant, and ethnically diverse communities.
www.diversityrx.org

Ethno-Med: Cross Cultural Health Care Program
Pacific Medical Clinics
1200 12th Ave. South
Seattle, WA 98144
(206) 326-4161
http://ethnomed.org

Fed Stats
Federal interagency search engine to assist in locating and accessing statistics and other data products of over 70 United States government agencies. Agencies link to a complete list of the data links accessible through this site.
www.fedstats.gov

Federal Web Locator
Quick access federal agencies and quasi-governmental divisions of the United States government; contains both direct links by agency abbreviation and a complete list of federal agencies and offices grouped by branch (Executive, Legislative, Judicial).
www.infoctr.edu/fwl

FirstGov
Official website of the U.S. government
Links to all federal and some state agencies
http://firstgov.gov

Health Resources and Services Administration (HRSA)
Parklawn Building, Room 10-49
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2964
www.hrsa.gov

HRSA's United States Health Workforce Personnel Factbook: 2000
Compiled data from secondary sources, such as the American Medical Association, and the Federal Bureau of Labor Statistics. Includes information on the supply of health personnel in several disciplines (physicians, dentists, nurses, chiropractors, physician assistants, and students entering those disciplines). Included are the geographic and specialty distribution of selected health personnel, and the participation of minorities and women in health professions schools.
(888) ASK-HRSA (888-275-4772)
www.ask.hrsa.gov

National Center for Education Statistics
www.nces.ed.gov

National Center for Health Statistics
www.cdc.gov/nchs
National Health Service Corps
(800) 221-9393
www.bphc.hrsa.dhhs.gov/nhsc/Pages/toc.htm

National Institute of Nursing Research
www.nih.gov/ninr

National Rural Health Association
One West Armour Blvd, Suite 203
Kansas City, MO 64111-3140
(816) 756-3140
www.NRHArural.org

National Rural Health Resource Center
http://www.ruralcenter.org/nrhrc

North Carolina Rural Health Research and Policy Analysis Center
Office of Rural Health Policy (ORHP)
Cartographic Archive (Maps)
Demographics of Rural America
Percent Minority Population – Non-metropolitan Counties
http://www.schsr.unc.edu/research_programs/Rural_Program/maps/min.html

Office for Civil Rights
USDHHS – 200 Independence Ave. SW
Room 506-F
Washington, DC 20201
(800) 368-1019
www.hhs.gov/ocr

Office of Minority Health
www.omh.gov

State Health Facts Online
http://www.statehealthfacts.kff.org

United States Bureau of the Census
www.census.gov/population/www/index.html

CHAPTER TWO

OBJECTIVES

After reading this chapter you should be able to:

- Differentiate between the terms "race," "ethnicity," and "culture."

- Describe components that are common across all cultures.

- Compare and contrast western cultural values with those of nonwestern cultures.

- Examine ethnic and cultural origins.

- Collect information on culturally based healing practices.

- Integrate literacy ability (skills) in clients' plan of care.

- Recognize barriers that can hinder effective communication with someone of another culture.

- List strategies to more effectively communicate with someone who speaks English as a second language.

- Acknowledge the value of integrating cultural and linguistical preferences into an individual's plan of care.

- Compile a list of bibliographic resources related to culture, health, and healing behaviors.

WHAT DOES "DIVERSITY" REALLY MEAN?

OVERVIEW

In the preceding chapter, U.S. demographic trends and issues related to diversity were examined. This chapter examines what the concept of "diversity" refers to and discusses characteristics and features of all cultures (cross-cultural). The content herein establishes a frame of reference for the next four chapters, which focus on the largest minority groups, specifically, African Americans (blacks), Native American & Alaska Natives, Asian/Pacific Islanders, and Hispanic/Latinos. Information on completing a cultural assessment is presented in Chapter 7; Chapter 8 focuses on cultural linguistic competence at the organization level; and Chapter 9 speaks to evaluation and research considerations with minority populations.

What do all of the words mean?

In discussions related to diversity, the terms "race," "ethnicity," and "culture" often are interchanged and sometimes misunderstood. Each of these terms will be discussed in greater depth within the next few paragraphs. (Box 2.1)

Race

Race refers to biological variations for the three major racial categories (Caucasoid, Negroid, Mongoloid). Biological (DNA) markers include such characteristics as color and thickness of skin, hair texture, physical and emotional development patterns, and susceptibility to certain diseases. The increasing number of persons who are of mixed race makes it difficult to differentiate distinct (pure) racial features. (See Chapter 1.) Rather, the term "race" has assumed social and political significance. The concept of racism, for instance, refers to an oppressive system of race relations, justified by ideology, in which one racial group benefits from dominating another and defines itself and others through this domination.

In becoming cultural linguistically competent, health professionals should make themselves aware of the more common racial/biological features of clients in their catchment area. For example, if there is a segment of African Americans, Native Americans, or some other ethnic group in the community, become familiar with physical variations and

Box 2. 1

Terms and Definitions

Acculturation
    Process of adapting/learning to take on behavior of another group; assimilating into the group
Culture
    integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups,* which guide thinking and actions of a group of people; transmitted from one generation to another
Cross-cultural
    Activity or behavior occurring in different cultures
Cultural belief
    Shared statements that individuals in a cultural group hold to be true. All beliefs are culturally bound
Cultural change
    Changes that occur as a result of contact with other groups or due to forces within or outside of the culture
Cultural shock
    Feelings of helplessness and discomfort experienced by an outsider trying to comprehend or adapt to another culture
Cultural values
    Prevailing or persistent guides influencing thinking and actions of members of a cultural group
Competence
    Implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities*
Cultural-linguistical competence
    Set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective work in cross cultural situations*
Ethnicity
    Affiliating with/belonging to a common group with shared heritage, often linked by race, nationality, and language
Poverty threshold
    Census Bureau criteria based on annual income in relation to family size (household); updated annually for inflation based on the Consumer Price Index
Race
    A socially defined population that is derived from distinguishable physical characteristics that are genetically determined

Racism
    An oppressive system of race relations, justified by ideology, in which one racial group benefits from dominating another and defines itself and others through this domination.
Stereotype
    Exaggerated/biased beliefs and images, popularly depicted by the mass media or folklore
Stereotyping
    An outcome of not recognizing individual preferences and abilities
World view
    Perspective shared by a cultural group of general views of relationships within the universe. These broad views influence health and health beliefs
Biculturalism
    The simultaneous identification with two cultures
Diversity
    Variations (differences) in race, ethnicity, language, nationality, or religion
Literacy
    Ability to read, write, and speak in English, compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential
Interpreter
    Human link between the speaker and the listener
Interpretation
    Oral restating in one language of what has been said in another language
    Simultaneous interpretation
    Concurrent oral restating (word-for-word) of what has been said; generally does not occur in health care settings
    Consecutive interpretation
    Delayed oral restating of what has been said in another language
Linguistic
    Referring to language; oral, written, nonverbal communication patterns and preferences
Translation
    Conversion of written materials from one language to another.

disease processes that occur with greater frequency in these groups, such as sickle-cell anemia, osteoporosis, diabetes, hypertension, or certain types of cancer. State and local health departments have epidemiological, mortality, and morbidity data relative to populations in a given region, and health care providers should become familiar with these useful resources.

Ethnicity

"Ethnicity" refers to a socially, culturally, and politically constructed group that holds a set of characteristics not shared by others with whom group members have contact. Ethnicity includes such things as common ancestry, shared historical experiences, the same language, similar religious beliefs, and the manner in which the members interact with outside groups. These features distinguish one group from another. Ethnicity is sustained by race, religion, and national origin and is influenced by other extenuating factors, including education, socioeconomic conditions, transportation, technology, and exposure to other cultures. Ethnic identity may change with internal and external political, historical, and economic influences on the group.

Not all members of a society express the same degree of ethnicity. Ethnic identity can be obscured by an individual's skin color, socioeconomic status, sexual orientation, and disabilities. Each ethnic group demonstrates certain patterns of beliefs and behaviors (generalizations), but that does not mean that all of the members adhere to these. Still, generalizations can serve as a starting point for health professionals to learn more about an ethnic group and/or the belief systems of individuals (clients) who are part of it. To reiterate, ethnic generalizations are not absolutes! Stereotyping is an outcome of not recognizing individual preferences and abilities. Moreover, stereotyping can lead to inaccurate assessments and inappropriate treatment interventions for individuals who are of a particular ethnicity.

For example, the term "Hispanic" is used in reference to all people who speak Spanish. However, Spanish is the language that usually is spoken in nations colonized by Spain several hundred years ago. Hispanics (Latinos) live in parts of Europe; North, South and Central America; and parts of the Caribbean and the Philippine Islands. Health care providers will find that most U.S. immigrants speak Spanish — albeit in a dialect. Each of these groups has distinct cultural and sometimes racial characteristics. Needless to say, there is great ethnic diversity among Hispanics in the U.S., but nearly 60% have Mexican-American origins. (Chapter 6)

Culture

The concept of culture can be metaphorically described as a tree with roots (usually not visible) and leaves (visible). In the tree of culture, roots include a group's value system, family structure and role behaviors, world views about life and death, and preferences related to space, time, community structure, and health beliefs. The leafy part of the tree of culture includes physical appearances, music, dress, dance, art, food, language, rituals, traditions, and celebrations. The belief system (root system) provides motivation for the visible aspect of the culture (leaves). For instance, cultural values dic-

tate ceremonies and rituals for developmental rights of passage, such as childbirth, menarche, marriage, menopause, aging, illness, and death.

Cross-culture dimensions

Outsiders generally do not have the complete picture about another cultural (ethnic) group. All cultures have the same basic organizational components, but all cultures are not the same. A more extensive discussion of the four predominant minority groups in the U.S. are discussed in greater detail in subsequent chapters of this text. (African Americans in Chapter 3; Native Americans and Alaska Natives in Chapter 4; Asians and Pacific Islanders in Chapter 5; Hispanic/Latinos in Chapter 6.)

Box 2.2

Cross-culture Dimensions

- social organizations

- communication patterns/preferences

- perception of space and boundaries

- time orientation

- perceived control of the environment

- health belief system

Values and beliefs associated with:

- socioeconomic status

- sexual orientation

- disabilities

Key components of a cultural group center on their social organization, communication patterns, perception of space, time orientation, control of their environment, and health-related beliefs. All of these dimensions should be taken into consideration by health professionals when completing an assessment on a client (individuals, families, communities) and when developing a treatment (intervention) to ensure that the care (service) is culturally and linguistically appropriate. (Box 2.2; Box 2.3) Each of these components will be discussed in subsequent paragraphs.

Social organizations

The family is the basic unit of society. Cultural values in turn influence its organization and the individuals' roles within it. The concept of family is difficult to define, and there are many variations of it. Traditionally, Anglo-American policymakers work from the notion of a nuclear family (i.e., mother, father, children/siblings). Some other cultures, however, describe "family" as a large kinship network (extended family) composed of blood relatives as well as those acquired by marriage. Or someone of a Latino culture may refer to all maternal aunts as "mother" and all maternal uncles as "father" in their family. Or a Native American may refer to all members within their clan (family) as "cousins." Some tribes (clans, families) have a ritual for adopting an unrelated person with whom they have a strong emotional bond; subsequently, the adoptee is referred to as "brother," "sister," "son," or "daughter" by other family members.

Box 2.3

EXEMPLAR: Select Western and Non-Western Cultural Values	
Western (Americanized) values	**non-Western values**
Personal control over environment	Fate, destiny, "God's will"
Change, variety	Tradition
Competition	Cooperation
Individualism	Group welfare
Future orientation	Past orientation
Directness	Indirectness and/or "in-your-face"
Informality	Formality
Time importance	Human interaction importance
Duration of life	Quality of life
Nuclear family	Extended family
Specialized medicine	Holistic healing

Other often-encountered family structures include: single-parent households (male as well as female heads of household); same-gender couples without and with children; grandparents who are primary caregivers for grandchildren; blended-family arrangements of all types and number; communal arrangements with and without children; and cohabiting unmarried couples of all ages. Given the diversity of family structures, "generic" assessment tools used within many health care institutions may not be valid or reliable. Likewise, many well-accepted research instruments are not sensitive to diverse family systems of various ethnic origins. (Chapter 9) Therefore, when completing the intake assessment, caregivers should inquire as to who the client includes as family and include those individuals in planning, implementing, and evaluating client care.

Social roles

Social roles and their associated behaviors within the family and community are culturally prescribed and vary among groups. More specifically, social behaviors for children and the elderly are culturally prescribed, as are gender roles for males and females. In some cultures, for example, the family decision makers regarding health matters are elder females. In other groups, these decisions are made by a male who heads the household. Sometimes females in the nuclear family expect to be directly involved in direct care-giving for one of its members. In other instances all members of the extended family (clan) expect to be actively involved when a loved one is hospitalized or dying. This latter preference may mean the health care providers extend visiting privileges, allow

Box 2.4

Facts about Literacy in the U.S.*

Increasing linguistic diversity!
- Nearly 32 million people in the United States speak languages other than English — a 38% increase over 1980.
- More than 50% of adults learning English as a second language are Hispanic. Other common first languages are French, Portuguese, Polish, Russian, Chinese, and Vietnamese.
- English for Speakers of Other Languages (ESOL) is the fastest-growing area of the adult basic education system.
- There is not enough space in ESOL programs for all who want to learn English. Most cities have waiting lists of several months to years; many rural areas do not offer ESOL classes.

More interesting facts!
- 1 in 5 (20%) high school graduates cannot read his or her diploma.
- 85% of unwed mothers are illiterate.
- 70% of Americans who are arrested are illiterate.
- 21 million Americans cannot read.
- More than 40 million Americans age 16 and older have significant literacy needs.
- Annually, illiteracy costs the U.S. about $225 billion in lost productivity.
- More than 20% of adults read at or below a 5th-grade level — far below the level needed to earn a living wage. Adults with low literacy skills earn the least. As literacy skills improve, average weekly wages increase. Of people with the lowest literacy skills, 43% live in poverty; 17% receive food stamps, and 70% have no job or only a part-time job.
- Workers who lack a high school diploma earn a mean monthly income of $452, compared to $1,829 for those with a bachelor's degree.
- When teens drop out of school, they are more likely to end up in the welfare system.
- Welfare recipients generally have low education and low literacy skills; 17- to 21-year-olds on average read at the 6th-grade level.
- About 50% of adults do not have a high school diploma or GED. Those having low literacy skills stay on public assistance longest; those with stronger skills become self-sufficient more quickly.

Literacy and health status!
- Individuals with low literacy skills often are not able to understand materials distributed by health care providers.
- Low birth weight is a condition that may increase a child's risk of developing health, learning, and behavioral problems.
- Children who are born at a low birth weight are more likely to be enrolled in special education classes, to repeat a grade, or to fail in school.
- Family literacy programs provide parents an opportunity to learn about child development, good health, and proper nutrition through groups that enable them to discuss health issues with specialists.
- Partnerships between literacy and health providers are making a difference in low-literacy communities.

SOURCE: Adapted from the National Coalition for Literacy www.nifl.gov/Coalition/nclhome.htm

family members to bring food that was prepared at home, or include an indigenous healer in the treatment plan. Sometimes the spokesperson in a family is the individual who has had the most formal education, especially if it was in a health-related discipline. For recent immigrants to the U.S., the spokesperson is the family member who speaks English, even though he or she may know only a few words and does not have interpreter skills. It is not unusual for a child, learning English in school, to become the family interpreter and sometimes decision maker regarding health matters.

Communication: patterns and preferences

One of the more obvious cultural variations is the manner in which members of a group communicate with one another. Communication is the verbal and nonverbal transmission of experiences, ideas, and beliefs among people. The process involves use of language, vocabulary, grammar, voice qualities, intonation, rhythm, speed, pronunciation, physical gestures, and silence. In the U.S., the dominant language is English, but that is being challenged in several states with large Hispanic populations. Even among English-speaking Americans, certain terms have different pronunciations, meanings, and nuances that are regional in nature. Consequently, individuals who speak English may not completely understand, or even may misunderstand, one another. The same can be said for Spanish-speaking people who are of different ethnic backgrounds.

Box 2.5

Select Cultural Barriers to Communication

Language patterns	Misinterpretation
Incorrect assumptions	Stereotyping/bias
Bias against the unfamiliar	Judging differences
Traditional values	Conflict with differences
Set expectations	Promoting conformity

Learning a second language can help one to communicate with persons who speak another language. It is important to be aware that foreign language courses generally teach the classic form of grammar and diction, but this style generally is not used in day-to-day communication. In such courses ethno-cultural nuances and regional dialects tend not to be included and sometimes even discouraged. In other words, the ability to read and speak another language does not ensure that one can effectively communicate with clients who use a dialect form of the language. Furthermore, it is not unusual for immigrants who recently have come to the U.S. to not be able to read or write the native language which they may speak fluently.

Translation and interpretation

Communication barriers intensify between two people when they speak different languages. (Box 2.4; Box 2.5) Language barriers are frustrating for all parties, even more so when someone is seriously injured or acutely ill and requires urgent attention. Increasingly, health professionals are impacted by language barriers. Ideally, all care-

givers should be able to speak the language spoken by clients; however, that expectation may not be realistic.

The terms interpretation and translation are often used interchangeably. *Translation* refers to the conversion of written materials from one language to another. *Interpretation* is the oral restating of what has been said in one language to another language. An *interpreter* serves as the link between the speaker and the listener; therefore, he or she should be able to accurately convey the tone, level, and meaning of the original message to the listener. *Simultaneous interpretation* is the concurrent oral restating (word-for-word) of what has been said. Usually this is used in formal meetings and conferences and generally does not occur in health care settings. *Consecutive interpretation* is the delayed oral restating of what has been said in another language. With the latter situation, the interpreter controls conversation flow, taking time to analyze, then restate the message for listeners.

In August 2000, former President Bill Clinton (in Executive Order #13166) directed federal agencies to establish written policies on language accessibility for their programs as well as those subsidized by their funds (*Language Assistance to Persons with Limited English proficiency [LEP]*). The Office for Civil Rights (OCR) published guidelines for organizations to maintain compliance with these regulations. (See Chapter 1, www.hhs.gov/ocr.) The American Hospital Association (www.aha.org), JCAHO (www.jcaho.org), and some states' regulatory agencies also require that accommodations be made for non-English-speaking clients. In other words, health care organizations are bound by law to provide equal access to care for persons having limited English proficiency.

Even though they often are called upon, especially in smaller facilities, family members may not be appropriate interpreters in a health care setting. Cultural rules based on age, gender, and position in the family dictate who can, or cannot, discuss personal health matters. In some cultures children and males should not talk with others about adult female reproductive-related matters. In other cultures, male health professionals should not speak to a woman unless she is wearing appropriate attire or certain body parts are covered, such as her face, legs, or the entire torso. To address those cultural preferences in a linguistically appropriate manner, a professional interpreter may be needed to communicate with a non-English-speaking client. Ideally, this individual should have knowledge about anatomy, physiology, illness processes, and medical terminology; be objective; and be able to accurately reflect what is being said by both parties. In turn, health professionals must use terminology the client and the interpreter can understand.

Translators, too, may be needed to rewrite English educational materials in another language. Again, it is important for a translator to be knowledgeable about the cultural and language nuances of the individuals who will be reading the translated materials. For example, Puerto Ricans living in a large city often are asked to translate materials from English to Spanish. Unfortunately, even though it is translated into Spanish, the information often is not understood or perhaps even is misunderstood by Spanish-

speaking Mexican farm workers who have had only a few years of formal education. (Box 2.5: Box 2.6)

Literacy skills

The National Literacy Act defines literacy as "an individual's ability to read, write, and speak in English, compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential." Lack of literacy skills has serious implications for the U.S. economy as a whole and impacts the health status and care-seeking behaviors of individuals and families. (Box 2.4) Additionally, limited literacy skills are associated with problems in accessing and progressing through the complex health care delivery system. For these reasons, health-related materials should be written at about the 5th-grade reading level. A formula for assessing the reading level of written materials is presented in Box 2.8.

To reiterate, it is not unusual for immigrants to be fluent in their native language but, because of little formal education, unable to read or write it. In these cases, translated materials are of limited use and the oral word must be relied on to communicate the message. Accessing an interpreter(s) and/or translator(s) may be a challenge, especially in smaller communities and in rural regions having a homogeneous population. Health and social service agencies may have a list of local interpreters who can speak various languages. Likewise, when several people in a region speak the same language, it is prudent to have English-foreign translation dictionaries readily accessible. Handheld/pocket computer translating devices are declining in cost and offer quick access to unfamiliar words. An option for interpreter services especially in rural areas is subscribing to a language line. A speaker phone makes the translation process less cumbersome. To obtain the service, subscribers usually are required to pay a one-time start-up fee, then a monthly minimum service charge. Use of interpreting services costs about $2.25/minute for Spanish and about $2.55/minute for other languages. The AT&T Language line is available to non-subscribers by calling 800-628-8486. It can be billed to a major credit card. Additional information can be obtained by calling 800-752-6069.

Box 2.6

Qualities of an Effective Interpreter

- Able to express ideas objectively and clearly

- Sensitive to cultural differences/nuances

- Understands technical health-related terminology

- Exhibits good command of English a second language

- Respects and maintains confidentiality

- Has accurate recall/memory

- Displays a mature understanding of physiologic processes

- Can elicit feedback from all parties (i.e., health care provider, patient, family, others)

Naming

Closely associated with communication patterns and social roles is the manner in which people are referred to (naming), and this varies across cultures. For instance, some families use select names across several generations, while others prefer to use nicknames. Among Mexican-Americans, several surnames are used, including the mother's, grandmothers', and in some instances father's name. In some Asian groups, the family surname may be stated before the person's birth name. Native Americans are given a birth name, but another one may be taken as part of the rite of passage for a significant life event. Immigrants with birth names that are difficult to pronounce or spell by Americans may elect to shorten or adopt a commonly used English name. Confusion can result when information provided on official records conflicts with word-of-mouth reports from a client and/or the family. Upon admission, individual preferences regarding name and title should be determined. Then, spelling and pronunciation must be carefully cross-referenced with official documents to ensure that all records have accurate information.

Social courtesies

Culturally based social courtesies have an important role in communication; for example, the small talk that takes place when initiating conversation with a stranger, or a health care provider assuming a professional demeanor when discussing highly sensitive issues with a client. Some cultural groups respond to direct questioning by "talking around" or using metaphorical descriptions of the problem, or elaborating on the effects of the condition on the person's day-to-day activities. Others provide a lengthy exposé of circumstantial information and expect the caregiver to understand the essence of their message.

For instance, Tania Smith, RN, expects to complete an intake assessment on Señor Rodriguez (the client) shortly after meeting him. Such information, while highly personal in nature, tends to be obtained in a hasty and efficient manner through direct questions on the part of the caregiver. Conversely, some clients (in this case, Mr. Rodriguez) are offended by such questioning on the part of a stranger — in this case Tania — who also happens to be a young woman. In some cultures, elders perceive such behavior to be a sign of disrespect, especially when engaged in by someone who is young and of the opposite gender. There is no one way or best approach to initiate a conversation with persons who are of another culture. Health professionals must be sensitive to each client's preferences and allocate adequate time to fulfill a client's expected communication courtesies.

Nonverbal communication

Nonverbal as well as verbal communication patterns are culturally based. For example, speaking very softly with the head slightly bowed and eyes cast down may be indicative of respect and deference for some people. For others, those same behaviors indicate shyness while yet others see it as evidence of slyness and dishonesty. Conversely, direct and prolonged eye contact may indicate a strong sense of self especially among "traditional" Anglo-Americans. However, for another culture this behavior is perceived

Box 2.7

Communicating More Effectively with Clients from Other Cultures

- Show respect for, and interest in cultural differences.
- Do not pass judgement.
- Health professionals and clients share in the responsibility for effective communication.
- Talk to clients in a setting in which they are comfortable asking questions and expressing feelings. As appropriate, involve family members in the discussion and decision making.
- Converse in a setting away from disruptions and noise; reduce outside distractions.
- Actions speak louder than words! Be sensitive to nonverbal messages that could offend the client; i.e., proximity to patient, posture, eye contact, hand gestures, touch, etc.
- Compare client's verbal comments with his/her non-verbal behaviors; is there congruence or incongruence between the two? What does this mean?
- Do not interrupt. Some cultures use metaphors or circumstantial events to describe their health concern.
- Do not rush to fill a brief pause. In other cultures, silence may mean the person is thinking about what was said or preparing to offer more information to the speaker.
- Listen to what the client says, as well as what is not stated. Try to understand the meaning behind the words.
- Use common language; avoid jargon, slang, and complex medical terminology.
- Maintain eye contact; but, be sensitive if clients is uncomfortable by this behavior.
- Observe body language to gain a more complete picture of what is occurring with the client and his or her family.
- Determine his/her level of fluency in English. If necessary, arrange for an interpreter.
- Determine literacy level prior to using written materials in the educational process.

- Focus on delivering the message. Use short simple sentences; repeat and/or rephrase information.
- Do not assume literacy even if the patient has gone to school.
- Put yourself in the other person's shoes. Approach the task from his/her point of view.
- Teach smallest amount possible. ("if I could get one [to three] ideas across at this time -what would they be?")
- Make it easy for the person to restate or demonstrate the information presented to them.
- Periodically, check for comprehension; Ask the client and/or another family member to repeat information that has been presented to them.
- Summarize and review repeatedly.
- With written materials offer low-literacy when ever possible. (no-more than 5th grade reading level)
- Be patient; when using an interpreter it may take longer to transmit the message. Be sensitive to words and concepts that do not exist in the culture of the client.
- Ask the client to define his/her family. Include those individuals in the treatment plan when possible.
- Respect the role that folk healing plays for clients. During the interview, ask "What do you think caused your illness?" or "We all have favorite remedies that we use when we are sick. What have you done to treat this condition?".
- When appropriate (and not contraindicated) incorporate 'benign' folk remedies into the treatment plan as a strategy to establish trust and improve adherence. For example, use of certain herbal products (e.g., chamomile tea) along with an electrolyte replacement as part of the therapeutic regimen.
- Consider having a caregiver of the same gender as the client in the room during a professional encounter.

as aggressiveness, disrespect, contempt, or even an overt sexual gesture. Another often-misinterpreted nonverbal message is when a client smiles and nods his or her head while another person is speaking. This behavior does not necessarily mean the person understands what is being said. Rather, it may be indicative of respect on the part of the listener for the speaker — but not understanding a word that is spoken. An example of a sometimes annoying behavior for caregivers is when another person responds to questions that are directed at a client.

Caregivers must be sensitive to cultural nuances and regional variations in language when communicating with clients. Generally, it is best to speak calmly, slowly, respectfully, and at a normal volume. Raising one's voice can be threatening or offensive to some people. Requesting that a client repeat the message in their own words can be an effective strategy to assess the client's level of understanding. If the client or someone in his family is literate, writing what was said can be useful should questions arise about the treatment plan. A translator may be needed to write the message in a language other than English.

Health care providers should always be respectful to clients! Regardless of the barriers, most can sense when another person is reassuring and well-meaning. A caring attitude goes a long way in establishing rapport and promoting effective patient-client communication regardless of the language barriers. Early on, assess a client's literacy skills and avoid using medical jargon when asking questions and providing information. Tailor the information to fit clients' level of understanding and reading abilities. Use words with which the client is familiar and involve family members when discussing the plan of care. Finally, ask for feedback to determine if the person understands and how the information will be accommodated in day-to-day activities.

Perception of space and boundaries

Perception of space and personal boundaries is culturally based and an important dimension of communication. Comfort zone refers to the acceptable distances among individuals in various social situations — for example, intimate situations versus business interactions versus receiving physical care. For example, in some parts of the world, upon meeting another person, shaking hands is a common practice. And compared to Anglo-Americans, Latinos seem to be more comfortable with less space in day-to-day situations and prefer touching the person with whom they are speaking. It is not unusual in some cultures for women to embrace each other as part of the initial greeting, even with a new acquaintance. In mideast cultures men embrace each other when meeting. For Americans, who usually prefer more space and are unaccustomed to being touched in public, an embracing gesture can be quite uncomfortable. Unsolicited touch may even be interpreted as sexual harassment in our society. Spatial preferences can become a source of conflict when interventions that involve touching the client are performed by a health care provider without first engaging in culturally prescribed social courtesies. A linguistically competent provider explains what will be done and then what is expected of the client prior to carrying out a procedure that involves touch.

Time orientation

Cultures are described as having a past, present, or future orientation. One must be very cautious when making general statements regarding time orientation because there is great variation within and among ethnic groups. Several general examples are offered in the next section to explain the notion of time orientation **along with an admonition** to avoid stereotyping all members of that particular group.

Many middle-class Anglo-Americans tend to be future oriented, believing that with hard work and delayed gratification they will be rewarded with the American dream at some future time. Future orientation can motivate one to engage in health-promoting behaviors to become healthier, more attractive, more physically fit, or even increase years in life expectancy. On the other hand, not achieving the hoped-for outcome can lead to a decrease in self esteem, increased stress, or even depression in the goal-driven, future-oriented individual.

African Americans as a group tend to be described as more present oriented. Again, consider the example of participation in health-promoting behaviors. A person with a chronic health condition such as hypertension or diabetes attends a family gathering to celebrate an event. He or she chooses to eat particular ethnic foods associated with the event even though these products are known to be high in salt, fat, and carbohydrates. In turn, this choice can exacerbate symptoms such as hypertension or uncontrolled diabetes. It is important to stress that this behavior is not unique to African Americans. Rather, it simply is used to exemplify the concept of present time orientation.

Cultures described as past oriented include some Native Americans, Native Alaskans, Asians and Pacific Islanders. The world view in these cultures is perceived to be circular as opposed to linear in nature. Deceased relatives are considered to be part of the extended family and are given great deference by living relatives. Those in the non-earthly realm provide guidance and support to living relatives. Consequently, it is not unusual for a client with a past perspective to incorporate healing practices suggested in a dream or vision by a deceased loved one. Past time orientation can be confusing and disconcerting for caregivers who are future oriented, especially when a client has an emotional or psychiatric disorder.

Time orientation is an often-cited source of misunderstandings between caregivers and clients –– for instance, client's versus caregiver's expectations as to when an intervention is to be carried out (timewise). On one hand, a patient expects to have a prescribed medication administered at the exact moment it is scheduled. Conversely, the nurse understands the hospital's policy that medications can be administered within a window of time — up to 30 minutes before and up to 30 minutes after it is actually scheduled. Or the conflict in time orientation is evident when the patient expects the call-light to be answered shortly after he or she turns it on. On a hospital unit that is understaffed, the nurse may not be able to respond to the call as quickly as the patient expects. Actually, when waiting for something to happen, time is perceived to pass very slowly, even more so when alone, in pain, or anticipating a major event. Time orientation may be a factor in whether a client keeps an appointment at a given time or engages in

health-promoting behaviors. The culturally and linguistically competent provider learns about clients' time orientation, then considers this world view when planning, implementing, and evaluating services for that individual.

Perceived control of the environment

Environmental control refers to the relationship that humans believe they have with nature. Some perceive humans as having mastery over nature, others perceive themselves to be dominated by it, and others believe the two must harmoniously coexist.

Those who perceive a mastery over nature believe the forces of nature can be overcome or that science can manage the environment. Such an individual probably expects to be cured of an advanced malignancy with a medical, pharmaceutical, or surgical intervention.

Those feeling subjugated to nature believe the person has little control over what happens to them. Those holding this view may not adhere to treatment protocol because they believe that nothing will change the outcome (their destiny) regardless of what is done to intervene. Cultural outsiders sometimes perceive this to be a fatalistic attitude.

The harmony-with-nature world view advocates that illness is an outcome of practices that disrupt that balance. Persons who hold this perspective believe that biomedical interventions merely disguise symptoms rather than heal the individual. They often use naturally occurring substances, such as herbs or hot / cold treatment modalities, to holistically restore the physical and spiritual imbalance that leads to undesirable symptoms or illness.

Health belief systems

Self care and folk healing are often thought to be used *only* by the poor and uneducated. Actually, all people use self-care practices in one form or another, and these practices usually are more accessible, economical, and validated by the community. Cultural world view is integral to the way an individual adapts to developmental transitions, remains healthy, and treats illness.

An indigenous healer usually is highly regarded in his or her community, and he or she may administer care in their own home or that of the client or a relative. Some products have been in use for thousands of years and are known to have healing properties, but others are highly detrimental — for example, a product may contain high levels of lead. Other products may have a placebo effect or lead to undesirable consequences when interacting with other medications or healing products. (Box 2.9) Intrinsic to use of folk medicine is understanding how the ordinary person defines health and disease (organic illness). From their family and community, a child learns what constitutes health and illness along with culturally sanctioned care-seeking behaviors, which include ways of treating health problems, the role of indigenous healers, and when to access professional services.

All cultures have healing systems based on their world view regarding the etiology of illness. Many cultures, modern as well as ancient societies, believed when one's

Box 2.8

Formula for Assessing Reading Level of Written Materials *

Ideally, written materials that are given to clients should be written at no higher than the 5th-grade reading level. This simple formula can be used to assess reading level of written materials.

1. Select and highlight a sample of 10 sentences from the beginning, middle, and end of the material (e.g., three sentences from the beginning, four from the middle, and three from the end of the document).

2. Circle, then count how many word have three or more syllables, even if the same word is repeated.

3. Total this number. (For example, 36 words in the 10 sentences sampled from the above section have three or more syllables.)

4. Choose the perfect square closest to this number; the perfect square is the exact square of the whole number (e.g., 49 is the perfect square of 7; 25 is the perfect square of 5; 36 is the perfect square of 6; etc.).

5. Figure the root, then add three (e.g., the root of 36 is 6; 6+3=9).

    Your answer represents a close approximation of the grade level at which the material is written.

* Adapted from: Sprager, L. 2001. Helping patients with literacy challenges. Migrant Clinicians Network — Streamline, 6(3), 5-6. www.migrantclinician.org

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body/soul is not in balance (harmony), illness is an outcome. In these cases, disease prevention may be completely alien. Others attribute illness to disruptions of natural conditions in the body and treat the symptoms accordingly (e.g., substances having either "hot" or "cold" properties). Folk illnesses often have psychological and/or religious overtones; hence, family involvement becomes intrinsic in the healing process, which includes rituals, ceremonies, and use of ethnobiological medicinals. There is a natural tendency to assume that personal customs are more sensible and right than those used

Box 2.9

Ethno-cultural products that contain lead*

Product	Use	Culture
Azarcon	Diarrhea and GI upset	Mexican
Greta	Diarrhea and GI upset	Mexican
Surma or kohl	Around eyes for cosmetic/ medicinal purposes	Indian & African
Pay-loo-ah	Rash or fever	Southeast Asian
Lozeena	Color for rice and meat	Middle Eastern
Farouk	Rubbed on gums for teething	Middle Eastern
Zahab	Colic	Middle Eastern

CDC Targeted Screening Guidelines for Lead Toxicity

Children should be screened for lead at 1 and 2 years of age (or between the ages of 3 and 6 if they've never been tested before) if they meet any of the following criteria:

- Receives services from public assistance programs for the poor, such as Medicaid or the supplemental food program for Women, Infants, and Children (WIC).
- Lives in an area where more than 27% of the housing was built before 1950. A list of these areas by ZIP code can be obtained from your state or local health department.
- Parent or guardian answers "yes" or "don't know" to any of the following questions:
  - Does your child live in or regularly visit a house, including a daycare center or the home of a babysitter or relative, that was built before 1950?
  - Does your child live in or regularly visit a house built before 1978 that is undergoing or has undergone remodeling or renovations in the past six months?
  - Does your child have a sibling or playmate who has or has had lead poisoning?

* Sources:
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by another culture. Consequently, caregivers often misinterpret health behaviors of other groups because they do not understand the underlying world view and cultural values.

Other cross-culture dimensions

Other conditions occur across cultures, but the associated perceptions may vary among groups, specifically regarding socioeconomic status, sexual orientation, and disabilities. A few comments will be made relative to each of these topics.

Socioeconomic status

Socioeconomic status (SES) is associated with personal income, level of education, and occupation. The notion of poverty (and wealth) is relative in nature, and each group differentiates the two based on cultural values and local economic structures. Compared to other nations, social class origin has less of an influence on lifestyle, values, behavior, and social relationships for U.S. residents. That reality has particular relevance for Anglo-Americans when dealing with immigrants who come from nations in which social class is a very powerful determinant in day-to-day social interactions. Additionally, better-educated (middle-class) immigrants from most foreign countries have more in common with each other and the dominant American society than with other immigrants from their country of origin who are of a lower socioeconomic status.

In respect to health status, poverty (low socioeconomic status) has been shown to be a stronger influence than are ethnicity and race. For instance, risk factors associated with poverty include unsafe or unavailable regular housing, exposure to industrial toxins, isolation, lack of or inadequate health insurance, restricted access to a regular health care provider and place of residence (remote versus rural versus suburban versus urban). Persons having an annual income below the poverty level have a death rate that is several times higher than those with an income at or above the national median. More specifically, racial and ethnic minorities are more likely to work in low-paying jobs, which do not offer fringe benefits including health care insurance. Or, an employer may provide coverage for employees, but not for the employee's family. Even if health care is available at no cost, an employee may not be able to take the necessary time off from work to see a health professional.

For example, going to the doctor for a health problem entails taking not only time to see the provider but also travel time — which can be excessive in rural areas. Once there, one usually must wait a few minutes to hours before seeing the doctor; perhaps wait for diagnostic tests; then wait again to have a prescription filled at the pharmacy. Consequently, it is not unusual for a seemingly short 15-minute doctor's appointment to actually require a full day that a person must take off from work — perhaps without pay.

Sexual orientation

Sexual orientation crosses all ethnic, racial, and socioeconomic groups. The majority have a heterosexual orientation, but increasingly individuals are acknowledging same-

Box 2.10

EXEMPLAR: Health Issues of Gay, Lesbian, Bisexual, and Transgender (GLBT) Populations *

DEFINITIONS

Heterosexist bias   The assumption that everyone is, or should be, heterosexual

Homophobia   The irrational fear avoidance of lesbians, gay men, or transgen-
                        dered persons; often involves violence or threats of violence

Sexual prejudice   Negative attitudes toward persons whose sexual or affectional
                        preference is different from the majority's preference

Antigay discrimination

                        Denial of services or accommodations, employment, promo-
                        tions, credit, housing, or benefits based on a person's actual or
                        perceived sexual or affectional orientation

Gender-related harassment, verbal and physical abuse

                        Slurs, demeaning language, humiliation, name-calling, pushing,
                        hitting, teasing, taunting, isolation, bullying, and/or physical
                        violence or threats directed at a person because of perceived sex-
                        ual orientation, affectional preference, or gender nonconformity

LIFE SPAN ISSUES

Adolescence
- OutRight Groups (adolescent-led GLBT support groups with adult supervisors)
- Family rejection/hostility (possible flight to urban areas, homelessness, etc.)

Early adulthood
- Relationships (gender and generational differences)
- Children (his, hers, ours, adopted, foster)

Midlife
- Retirement
- Financial, legal, health planning(without benefit of 'legal' marriage)

Old age
- Health care, long-term care, loss of privacy
- Planning for death, funerals, inheritance

PRACTICE ISSUES (IN RURAL AREAS)
- Accessibility of services
- School-related issues (language, role models, support, personal safety)
- Hospitals and emergency care
- Practitioners who are knowledgeable about GLBT issues/health problems
- Skilled nursing facilities

* Source The National Lesbian and Gay Health Association. 2000. Removing barriers to health care for
lesbian, gay, bisexual, and transgendered clients: Trainer handbook. *Washington, DC: Author.*

gender or bisexual orientation and/or transsexual orientations. More than likely the proportion of individuals having an alternative sexual orientation has been consistent over time, but more people may be "coming out" and acknowledging their preference. In some regions lesbian and gay subcultures are more visible than in others. Similarly, some families and communities are more tolerant of persons having alternative sexual preferences. For variety of reasons, in rural areas persons having same-gender sexual orientation generally remain less visible, sometimes hidden, and often discriminated against. Consequently, health professionals are unaware of the special needs of gay and lesbian clients, in particular if they are of a minority ethnic or cultural group. Sexual orientation also may be associated with certain types of behavior that place that individual and others in their network at risk for certain conditions, such as HIV infection. (Box 2.10)

Disabilities

Disabilities of all types cross ethnic, racial, and socioeconomic boundaries, too. Perhaps the term "abilities" (as opposed to "disabilities") is more appropriate since all humans are unique; each possesses a particular genetic make-up as well as attributes and skills. All humans are challenged in some ways, too. Much like sexual orientation, disability is viewed differently in various cultures. Sometimes physical and emotional conditions are given a spiritual connotation such as seizure disorders and certain emotional conditions. More often, though, persons with a disability or malformation are stigmatized. In the U.S., individuals with impairments (challenged physically, mentally, emotionally, etc.) are legally entitled to the same rights as others and should be integrated into the wider society. (See Chapter 1.)

Epidemiology: how does it all fit together?

Epidemiology links race, ethnicity, culture, race, socioeconomic status, and lifestyle behaviors to health. Compared to the dominant culture, "at-risk" populations often include racial or ethnic minorities who do not have equal (similar) opportunities for education, employment, and economic success. Minorities are disproportionately represented in the lower socioeconomic levels and have a poorer overall health status. Disadvantaged groups share some common characteristics, specifically living in poverty, being of a racial or ethnic minority, fewer years of formal education, a higher incidence of chronic health problems, lower life expectancies, and poorer pregnancy outcomes. Minorities experience additional economic, legal, linguistic, and cultural barriers when trying to access health care services. Culturally and linguistically competent providers must take these factors into consideration when planning, implementing and evaluating services targeting a particular ethnic minority group.

SUMMARY

Thⁱs chapter focused on diversity in reference to race, ethnicity, and culture. Cross-culture components were examined, specifically social organization, communication patterns, perception of space, time orientation, control of environment, and health-related beliefs. This information established a framework for completing individual cultural assessments and for developing culturally and linguistically appropriate interventions and services. The next four chapters integrate information from Chapter 1 and Chapter 2 with the cultural health beliefs of the largest minority groups, specifically, African Americans (blacks), Native American and Alaska Natives, Asians and Pacific Islanders, and Hispanics/Latinos.

CHAPTER TWO

Discussion Questions

- Compare and contrast the terms "race," "ethnicity," and "culture." Select one or two minority (ethnic) subgroups in the community and provide examples for the terms.

- Discuss how the *Language Assistance to Persons with Limited English Proficiency* (LEP) federal requirement can be implemented in your facility. Identify particular languages that are most prevalent in your catchment area. How can interpreter and translation resources be accessed to meet the needs of individuals in that population?

- Identify cultural or ethnic groups within your community. Use the cross-cultural features discussed in this chapter to develop health-related resource materials for each cultural/ethnic group for employees within your institution (e.g., food preferences, religious practices, self-care practices, health care–seeking behaviors, language, family structures, decision-making style, sexual/affectional orientation, etc.). How are these the same or different from your preferences and beliefs?

- Interview several friends or co-workers to learn about self-care practices they use to stay healthy and to treat common health problems. How are these similar and different from those you use? Describe ethnic healing preferences of other cultural groups in your community.

- Obtain a document with health-related information that is given to patients/clients in your practice setting. Using the formula in Box 2.8, assess the reading level of the materials. Analyze the strengths and weaknesses of the written material. How could it be made more culturally and linguistically appropriate for the targeted audience?

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American Translators Association
225 Reinekers Lane, Suite 590
Alexandria, VA 22314
(703) 683-6100
www.atanet.org

Association for Multicultural Counseling and Development
5999 Stevenson Ave.
Alexandria, VA 22304
(800) 347-6647
(703) 823-9800
www.counseling.org

Cross Cultural Health Care Program
Pacific Medical Clinics
1200 12th Ave. South
Seattle, WA 98144
(206) 326-4161
www.xculture.org

National Agenda for Nursing: Workforce Racial/Ethnic Diversity
www.bhpr.hrsa.gov/dn/nacnep/diversity.htm

National Center for Cultural Healing
2331 Archdale Road
Reston, VA 20191
(703) 264-1994
www.culturalhealing.com

National Rural Health Association
One W. Armour Blvd., Suite 203
Kansas City, MO 64111
(816) 756-3140
www.NRHArural.org

Office of Minority Health
www.omh.gov
National Center for Cultural Healing
2331 Archdale Road
Reston, VA 20191
(703) 264-1994
http://www.culturalhealing.com

RN Advocate
contains a list of active links to numerous RN-related websites
http://www.rnadvocate.com/nursing.htm

OBJECTIVES

After reading this chapter you should be able to:

- Describe demographic trends within the black community.

- Discuss sociocultural and economic issues impacting the health status of African Americans.

- Compare and contrast the health status of African Americans with other predominant racial groups.

- Compare and contrast the health status of African Americans in rural areas with their counterparts in urban areas.

- Highlight health disparities among African Americans.

- Demonstrate sensitivity to cultural and linguistical preferences of African American clients.

- Compile a bibliographic resource list related to African Americans, their cultural beliefs and health status.

AFRICAN-AMERICANS (BLACKS)

OVERVIEW

This chapter provides information about African Americans, the largest racial minority group in the United States. To be reviewed are demographic trends, socioeconomic issues, health status, and patterns of accessing health care among the black community. General cultural and linguistic characteristics will be highlighted. The content in this chapter can be a starting point for health professionals to learn more about the beliefs and values of African American clients.

Demographic trends

Diversity describes the African American (black) population living in the United States — ethnically, culturally and socioeconomically. According to preliminary Census 2000 reports, the black population is continuing to grow but at a modest rate. Of the total population, blacks represent about 12.3% of the U.S. population, slightly more than Hispanic/Latinos. While African Americans are located throughout the U.S., more live in urban areas and in the southeastern states, particularly in the Mississippi Delta region. In some Mississippi counties African Americans constitute 50% or more of the population. Rural blacks predominantly live in southeastern states. Figure 3.1 displays the distribution of blacks in nonmetropolitan areas of the United States. (www.schsr.unc.edu/research_programs/Rural_Program/maps/black.html)

The majority of black citizens are in families who have resided in the U.S. for four or more generations. Many of their ancestors arrived here as slaves more than 200 years ago but some in the black community are recent immigrants. Of all foreign-born U.S. residents, blacks constitute 8%, coming from all parts of Africa and Haiti. Of the nearly 35 million blacks living in the U.S., about 2 million are recent immigrants from Africa. The following states and the District of Columbia have significant numbers of black refugees: California, Florida, Georgia, Illinois, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, New Jersey, Pennsylvania, South Dakota, Texas, Virginia,

and Washington. Children in immigrant families are the fastest-growing component of the U.S. child population, particularly children of color.

Socioeconomic status
http://www.cdc.gov/nchs/statestatsbysexrace.htm

There are wide extremes in blacks' socioeconomic status. Even though there has been gain in their median income over the past several years, as a group African Americans continue to lag behind the overall U.S. population in material wealth. When this text was prepared the mean income by race was not yet available from the Census Bureau for the year 2000. However, in 1996 the median income for African American households ($23,482) was about $12,000 less than the average median income for the population as a whole. These additional socioeconomic facts demonstrate the economic disparity between blacks and whites in the U.S.:

- The percentage of African Americans living below the poverty level is twice that of the overall population. About 50% of the African American population is classified as poor or near poor.

- More than two-thirds of black children live in or near poverty.

- African Americans have not advanced to the same educational levels as the overall population, and this disparity is reflected in the workplace. Of the African American population between the ages of 25 years and 64 years, a greater proportion (about 20%) have not completed high school compared to the overall population (15%). Comparing those who have at least a baccalaureate degree, fewer blacks (15%) have achieved this degree than the general population (25%).

- Of men who hold blue-collar positions in the workforce, a lower proportion of the total population (40%) are employed compared with all black men (50%). Of the remaining black male workforce (50%), about two-thirds (66%) held white-collar positions; the remainder (33%) were employed in the service sector.

- The occupation patterns of African American women reflect those of their male counterparts. Of all African American women in the workforce, most held white-collar positions (60%); followed by the service industry (25%) and blue-collar positions (15%).

- Among the U.S. civilian population (non-institutional, 16 years of age and older) in the labor force, the African American population has the lowest annual average employment rate (57.4%), compared with whites (64.1%) and persons of Hispanic origin (60.6%).

- The annual average unemployment rate for African Americans is higher (11.2%) compared to whites (4.6%) and people of Hispanic origin (8.9%) (U.S. Bureau of the Census, 1997).

- African Americans who advance to the highest levels of the educational system earn less than their white colleagues. Comparatively, African American men who held at least a baccalaureate degree earned approximately $12,000 less than white men with similar educational backgrounds. African American females with baccalaureate degrees or higher earned $4,000 less than white females with similar educational backgrounds. (U.S. Bureau of the Census, 1998)

- Compared to Asians and whites, there are a higher number of African American single-parent households. (See Chapter 1.) Of all African American households in 2000, 29.4% were headed by a single parent (down from 54% in 1996), compared to Hispanics (18.3%), whites (7.4%), and Asians (5.1%). In 1996, more black women (47%) were single heads of household than were black men (7%). The median income for African American female-headed households was lower ($15,530) than for white female-headed households ($22,370). (U.S. Bureau of the Census, 1998;2000)

Health status
www.cdc.gov/nchs & www.omhrc.gov & www.cmwf.org

Life expectancy in years has increased for the U.S. population as a whole and for blacks in particular. However, people in the black community still do not live as long as their white counterparts (Chapter 1). Life expectancy for blacks who were born in 1995 reached an all-time high (66 years), which was about eight years less than whites. On average, of those born in 1996, the life expectancy of black men was about seven years less than white counterparts, and for black women it was about five years less than the life expectancy for all U.S. women. Leading causes of death for African Americans included heart disease, lung cancer, cerebrovascular disease, HIV/AIDS, unintentional injuries, prostate cancer, homicide, diabetic complications, breast cancer, pneumonia, influenza, chronic obstructive pulmonary disease, and perinatal conditions. African Americans die from several of these diseases at dramatically greater rates compared to the total U.S. population, specifically:

- African Americans died at twice the rate from prostate cancer and diabetic complications than the overall population.

- The age-adjusted mortality rate for stroke for the black population was 66% higher than that for the overall population.

- Of the 10 leading causes of death for the African American population, two of these conditions did not rank among the 10 leading causes of death for the overall population (HIV/AIDS, homicide). In fact, HIV/AIDS mortality rates for the African American population were nearly four times higher (41 per 100,000) than the overall population (11 per 100,000).

- Homicide rates for African Americans were more than three times greater (31 per 100,000) than the overall population (9 per 100,000).

In reviewing the goals put forth in *Healthy People:2000* the following are some of the outcomes in the black population. First, the good news!

- African Americans have met the *Healthy People:2000* target for cancer deaths, and age-adjusted death rates for this disease continue to decrease.

- The incidence of Hepatitis B has been on the decline and this target indicator was met.

- Deaths from lung cancer and from unintentional injuries have steadily declined and target goals have nearly been met. However, the rate of decrease for these two health indicators must be greater for the numbers of African Americans who die from lung cancer or unintentional injuries to approach the numbers for the overall population.

- Increasing numbers of African American women have had breast exams and mammograms, and they are beginning to reflect the national norm. The challenge is to have an increasing number of black women who receive mammograms and breast examinations on a regular basis.

- The percentage of low birth weight and infant mortality has steadily declined among blacks (from 1991 [13.6%] to 1996 [13.0 %]). However, the percentage of very low birth weight babies remains the same (3.0%). The rates of decrease for these three indicators will need to continue for the African American population to achieve parity with the overall population.

- Coronary heart disease deaths have been declining since 1987, and this *Healthy People:2000* target has been achieved.

- Homicide continues to be one of the leading killers of African American males. The death rate from homicide for African American males (ages 15 through 34) has declined since 1991. However, the disparity in homicidal death rates between African American males and the overall population is still alarming.

There continues to be a widening disparity among blacks associated with the burdens of illness and early death as evidenced by their progress in achieving *Healthy People:2000* indicators. Even though several indicators are moving in the right direction (breast cancer deaths, incidence of tuberculosis, early prenatal care, hospitalizations for pelvic inflammatory disease, incidence of primary and secondary syphilis, and pneumococcal and influenza vaccinations) other *Healthy People:2000* targets were not achieved. More specifically:

- Since 1989, the rising incidence of AIDS was less dramatic for the entire African American community. Over the same time period, the incidence of AIDS remained fairly constant for the overall population. As mentioned in Chapter 1, in recent years there has been an increase in new infections among black males who engage in homosexual activities.

- The incidence of HIV increased dramatically from 1990-1995 in subpopulations of the African American community — specifically, heterosexual females, female intravenous drug users, and homosexual males born between 1965 and 1974. In other

Figure 3.1

DISTRIBUTION OF NONMETROPOLITAN BLACK POPULATION, 1990
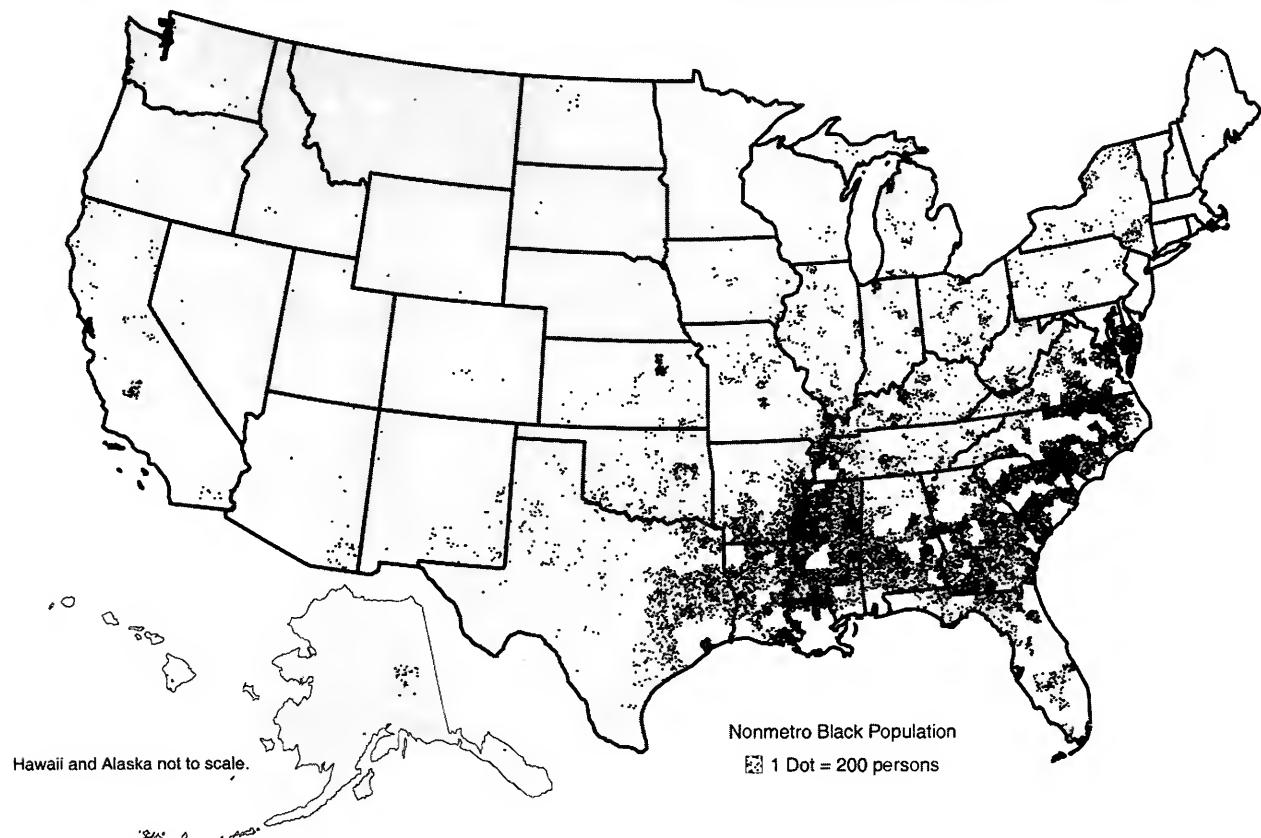
Hawaii and Alaska not to scale.

Nonmetro Black Population

1 Dot = 200 persons

Note: Metropolitan counties are aggregated into white areas on the map.
Source: US Bureau of Census, 1990.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS.

words, the gap in new HIV infection rates in blacks is higher and continues to increase at a faster rate, especially among women and in rural areas.

- The age-adjusted death rate from asthma in the African American community has been greater than that of the overall population. The number of asthma hospitalizations among blacks has increased since 1987, thus, not achieving targets put forth in *Healthy People:2000*. The trend has been relatively unchanged for the overall population with respect to asthma hospitalizations.

- While remaining stable in the overall population, maternal mortality and diabetes-related deaths have been increasing in African Americans. The age-adjusted maternal mortality rates for African American women were five times greater than among non-Hispanic white women.

- Two indicators related to diabetes-related deaths are a result of complications associated with the disease: end-stage renal disease and lower extremity amputation. These conditions are similar for the overall population and African Americans. How-

ever, complications of diabetes affect the overall population to a lesser degree, and African Americans die from diabetes at more than three times the rate of whites.

Even though there has been some improvement in the health of African Americans based on *Healthy People:2000* indicators, blacks continue to lag behind whites. Many factors account for health status differences. However, having health insurance coverage and better access to health care services could reduce many of the disparities that exist among African Americans.

Patterns of accessing health care
http://www.healthpolicy.ucla.edu/publications

The Kaiser Commonwealth Fund 1997 National Survey of Health Insurance reports that blacks are more likely to be uninsured (19%) than whites (16%). Blacks also are more likely to receive Medicaid (25%) than whites (9%). Seven out of every 10 African Americans receive care through some kind of managed-care arrangement, slightly more than the population at large. Nationally, of all African Americans, about 56% have private health insurance coverage; Medicaid covers an additional 21%; but almost one-quarter (23%) are uninsured. The uninsured rate for African Americans is more than one and a half times the rate for white Americans, largely because of gaps in employer-based coverage. Although eight out of 10 African Americans are in working families, employer-sponsored health insurance among African Americans remains substantially lower (53%) than for whites (73%). A strong national economy has improved access to job-based health benefits for some citizens. However, a number of factors continue to place African Americans in the workplace at a disadvantage, including less education, lower pay (even when similarly educated), and discriminatory practices.

To reiterate, a wide income gap exists between African Americans and whites. Of all African American families, more than half have annual incomes of less than 200% of the poverty level. Lower family income translates to a lower likelihood of having employer-based health coverage. Compared to whites, African Americans are less likely to have job-based coverage at all income levels even though they are more likely to work in large businesses that typically offer health benefits. African Americans are substantially less likely than whites to receive job-based coverage regardless of the size of the industry.

Medicaid provides an important safety net for one in five African Americans; covering 50% with incomes below poverty and 17% of those between 100% and 199% of poverty. Medicaid's protection is incomplete, leaving 30% of African Americans who fall below 200% of poverty uninsured. Welfare reform resulted in many individuals moving into low-wage entry-level positions, where health benefits are less likely to be offered or affordable. Among blacks, there was a sizeable decline in Medicaid and other publicly funded coverage from 1994 (27%) to 1997 (21%) even though states were required to continue coverage with the (State) Children's Health Insurance Program ([S]CHIP) for families moving into the workforce (Chapter 1).

Among African Americans living in poverty, the uninsured rate grew from 24% to 30% over the past few years. Regardless of race or ethnicity, people who do not have insurance or are inadequately insured are at greater risk for developing certain chronic conditions. In other words, having private health insurance or Medicaid results in better access to care. Lack of one or both of these resources is a contributing factor to health disparities in blacks evidenced by the following findings.

- Uninsured African Americans are at least three times more likely than those with private insurance or Medicaid to be without a usual source of care.

- Over a third of uninsured African American and white adults do not have a regular place to go for their health needs. Uninsured African Americans are much less likely to have seen a physician over the course of a year than are those with private or Medicaid coverage.

- Uninsured women, even those in fair or poor health, are at least half as likely to meet basic physician's visit guidelines. African American women in fair to poor health are less likely than white counterparts to have had a doctor visit in the past year.

- Regular check-ups are important to assess both physical and social development, as well as to provide parents with age-appropriate preventive information. Among uninsured African American children, 20% of school-age children and 10% of younger children have not seen a physician even once in the past year.

- Rates of physician visits for men are roughly equal between races, but men are less likely than women to have seen a doctor in the past year. Lack of coverage adds to the disparity. For example, over one-quarter of uninsured men who are in fair or poor health have not seen a doctor in the past year. Many have chronic conditions that need ongoing evaluation and management.

Regardless of race or ethnicity, having health care coverage (insurance and/or Medicaid and/or Medicare) definitely impacts an individual or family's ability to access health care. Better access, in turn, is associated with better health status.

Recruitment, retention, and education of health professionals

African Americans are significantly underrepresented in the health professions. African Americans make up about 13% of the nation's population, but this proportion is not represented in the health professions. In 1999, for example, only 2.8% of non-federal physicians were black. A report by the Office of Minority Health listed the following numbers for black physicians and nurses: osteopathic medicine (3.5%), allopathic medicine (7.6%), and nursing (9.0%). An adequate supply as well as equitable geographic distribution of African American health professionals is essential to improve the health status of African Americans. (HRSA — *U.S. Health Workforce Personnel Fact Book 2000*, www.ask.hrsa.gov. (Also see Chapter 1; Chapter 7; APPENDIX C.)

Box 3. 1

SELECT AFRICAN AMERICAN LIFE TRANSITIONS & HEALTH BEHAVIORS

Child bearing

Prenatal care varies with level of education, age, and knowledge about health care; more than half seek prenatal care after first trimester; otherwise seek care when problem perceived or when care is perceived as helpful and is accessible; active participant during labor and expression of pain can be quite open — use of medication varies but is not avoided; traditionally only females in attendance; father's role varies with individuals level of health care education; vaginal deliveries preferred but will accept cesarean section if necessary; breast feeding varies with level of education and information provided by other dominant females in the family — most willing to breast feed when instructed of the benefits; family members care for mother and baby, (depending on socioeconomic level/resources); no tub bath/shower or hair washing until after cessation of postpartum bleeding; new mother relies on older females in family (mother/grandmother) to assist with newborn's problems

Child rearing

early walking and talking by child encouraged; children expected to help with household chores, attend and complete school; encouraged to develop talents in sports and music; discipline and appropriate behavior emphasized, and elders often involved in rearing of grand/great-grandchildren

Serious & terminal illness

hold family conference, talk with family elder, pastor; patient may prefer having older relative reveal poor prognosis; usually (but not always) open/public expressions of grief and sadness

Death & dying
    place
    varies with individuals/families; frequently dying elders cared for at home until death is imminent, then bring to hospital; some believe death in the house brings bad luck; deceased are highly respected

    care of the body
    family usually prefer that professionals cleanse/prepare body; cremation avoided

    organ donation
    donating organs/blood taboo; some believe this will hasten the death of the donor; exceptions for immediate family member when educated about the need for organs/tissue in the black community; sometimes religious restrictions (Jehovah Witness; Christian Scientist, etc.)

    autopsy
    may accept if need clearly explained; discuss end-of-life/advanced directives with family before serious illness and death occurs

Sources: Geissler, 1994; Livingston, 1994; Locks & Boating, 1996

Cultural & linguistical characteristics

The black population in the U.S. is highly diverse ethnically, culturally, and linguistically. The next few sections provide general background information on cultural features of some black communities. The information, however, may not be applicable to recent U.S. immigrants or refugees from various Africa nations or Haiti. To reiterate, the information included in the next few paragraphs *is not absolute*! Rather, it is a starting point for health professionals to learn more about the cultural and linguistic preferences of clients of color having African origins. Many African American families have lived in the U.S. for a longer period of time than Anglo-American counterparts. Box 3.1 summarizes examples of select life transitions and associated health practices by some members of the African American community. (Also see Chapter 2.)

Ethnic identity

Historically, earliest arrivals on American shores were black indentured servants in the early 1600s. Eight million more were brought to America as slaves during the 18th and 19th centuries. It is important to note that recent immigrants (refugees) with origins in Africa and the Caribbean Islands share some common history but perceive it differently than decedents of slaves who have resided in the U.S. for many generations. The manner in which blacks refer to themselves varies with their degree of acculturation into American society, place of residence (rural versus urban), ethnic origins, age, level of education, socioeconomic status, and in some cases religion, philosophical, and political beliefs. Titles that have been used over the decades in reference to blacks include: person of color, Negro, black, African American, Afro-American, and American from Africa.

Social organization

Consistent with American families in general, there is a wide range of family structures in the African American community. In general, it is matriarchal in nature. The nuclear family embraces extended family, which can include close friends as well as relatives. In younger families, women and men are seen as separate but equal. In some instances, the father or eldest son becomes the family spokesperson and decision maker. In other cases the grandmother and/or maternal aunts assumes the role of caretaker for children in the family. Sons often assume the responsibility of caring for ailing parents. Elders are viewed as a source of wisdom and demand respect. There is a preference of caring for elders in the home, and institutionalizing them or children with disabilities is avoided.

Religion and spirituality are important to African Americans. The church (faith community) historically has been an important institution and continues to be a source of support and education for modern African American families. The faith community continues to be a key partner in federal, state, and local initiatives that focus on African Americans. The most commonly represented denomination in this population is Baptist, followed by other Protestant sects, and Islam. Certain religions tend to be more predominant in particular regions of the nation. Aspects of spiritual care are important during illness, too. When hospitalized it is not unusual for an individual to expect prayer visits from the minister or pastor. Some religious sects may prescribe certain activities or

health-promoting behaviors for members, such as wearing prayer beads or a cross, adhering to certain bathing rituals or abiding by specific food restrictions (e.g., Islam, Seventh Day Adventist).

Regarding alternative sexual/affectional preferences, homosexuality generally is viewed as aberrant by African Americans. With the escalating incidence of HIV/AIDS infections in blacks, families and communities are becoming more accepting of individuals having this sexual orientation. The faith community has assumed an active role in advocating for an array of services to meet the complex and multiple health needs of people having HIV/AIDS. It also has assumed a leadership role in reminding the family to be more tolerant of individuals with alternate sexual preferences.

Communication patterns and preferences

African Americans for the most part speak English, but there are regional dialects. More distinct dialects are noted in rural areas of the south and in the inner city. Immigrants and refugees from Africa may speak English as a second language, their first being French or a native African language. English literacy skills vary with an individual's level of formal education, socioeconomic status and length of time in the U.S. (Chapter 2). For example, an elderly person may be visually impaired and not able to afford glasses and, thus, not able to read printed material. Or a recent immigrant may understand day-to-day conversations in English but not be able to read and write in English or understand technical (medical) terms. Culturally and linguistically competent providers understand that when a client, regardless of race or ethnicity, refuses to sign a consent form it could be indicative of low literacy skills rather than him or her being uncooperative.

Nonverbal communication patterns vary depending on the individual's background. Generally, among African Americans who have lived in the U.S. their entire lives, communication patterns are similar to mainstream society. For example, direct eye contact shows respect while silence may be perceived as someone who is untrustworthy. There may be some subtle differences, though. For instance, when speaking to each other, African Americans' conversational tone can seem rather loud and animated while some individuals become quite emotional when feeling threatened, anxious, or frightened.

In general, African Americans are affectionate people evidenced by touching, hugging, and preferring to be in close proximity with friends and family. Most welcome visitors to the home and traditionally celebrate family events. As hospitalized patients, they anticipate having visitors who often bring food (especially desserts) to them. Family members may or may not prefer to sleep at the bedside of a sick person.

Time orientation

Consistent with social structures and communication patterns, time orientation among African Americans will vary depending on a person's level of education, exposure to mainstream American culture, and experiences with traditional workplace values. In general, there is a preference for present-oriented, nonlinear, and flexible time. "CP (Colored people's) Time" infers 'when everyone gets there'. A community meeting

Box 3. 2

EXEMPLAR: SELECT AFRICAN AMERICAN HEALTH PRACTICES

blood problems & circulation
food prescriptions such as cooked greens, fresh fruits, red/yellow vegetables

pain
wide variations but generally express pain openly; may avoid pain medication in fear of becoming addicted; pain scales useful to rate level of discomfort

dyspnea
"difficulty catching breath"; when physiologic process explained may accept oxygen/medications to manage symptoms; strong fear of becoming addicted

nausea & vomiting
preference for nonpharmacological intervention, i.e., ginger ale, soda crackers, teas; may take intravenous medication when symptoms are severe

constipation& diarrhea
"bowels tightened/blocked up"; accept nutritional intervention ("roughage" — prunes and other fruits); older individuals more likely to become upset if daily bowel movement does not occur — may welcome an enema to manage symptoms

fatigue
"having a spell"; "tired state" — may take sleeping pill to aid in sleeping

depression
rarely acknowledge depression; with education may accept medication to manage symptoms

* Sources: Locks, S., & Boating, L. 1996. Black/African Americans. In J. Lipson, S. Dibble, & P. Minarik (eds.), Culture and nursing care: A pocket guide. San Francisco: UCSF School of Nursing.

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or family gathering may be scheduled to start at 1:00 p.m., but attendees will arrive as near to that time as it fits the individual's schedule. Thus it is not unusual for the function to "officially" begin an hour or two after it was originally scheduled. Family simply give various times in order to "start" on time. No one seems to be bothered by this occurrence except future oriented Anglo-Americans. African American people's flexible perception of time often conflicts with rigidly scheduled appointments. It is not unusual to hear an African American report that life issues take priority over keeping an appointment. Older individuals, however, tend to be more punctual and willing to wait for and during an appointment.

Control of the environment

Perceptions related to control over the environment vary among individuals based on life experiences, age, education, socioeconomic status, and religious beliefs. It is not unusual for African Americans to feel quite vulnerable, stemming from a long history of abuse — first as slaves and later as uninformed subjects in such research projects as the Tuskeegee syphilis study. With ongoing education, respect, and accurate information, African Americans are becoming more receptive to participating in research studies and clinical trials. (Chapter 7; Appendix B)

Health beliefs and practices

In light of the cultural diversity within the African community, there are corresponding variations in how individuals define illness and health. Therefore, health professionals should not assume that because a patient is black, he or she adheres to a certain lifestyle. In general, African Americans abide with mainstream American health beliefs. Traditionally, African Americans enjoyed diets that were hearty, including meat, fish, greens, rice/potatoes, and other starches (corn/yams), but there are regional variations. "Soul foods" are preferred by many, especially by adults and the elderly, but these tend to be high in animal fat, salt, and carbohydrates. With extensive public education related to preventing obesity, hypertension, and Type II diabetes, many African Americans are trying to modify their nutritional preferences to prevent these chronic conditions and manage symptoms once diagnosed with disease.

Among African Americans the concept of health indicates a "feeling of well-being" and being able to fulfill role expectations within and outside the home. It also means being free of pain and excessive stress. Health promotion and illness prevention involve eating a proper diet, exercising, getting plenty of fresh air, and protecting against excessive cold. Historically, African Americans believed physical illness was related to natural causes, such as poor eating habits and exposure to cold air or wind. Some problems are attributable to unnatural causes, expressed as "God's punishment" for improper behavior, not living according to His will, "work of the devil," or a "spell." Mental illness and genetic defects are considered by some to be caused by God's will or not having spiritual balance in life.

Being ill (i.e., sick role) indicates that the individual will not be able to work and, hence, not able to carry out usual responsibilities. Attention and assistance is expected from family members and relatives, but the person maintains independence. Self care usually is the first intervention. Usually the female head of household (wife or mother) uses a remedy obtained from a "knowing person," such as drinking an herbal tea, applying a poultice, or inserting pieces of cotton into the nostrils or ears to protect against cold entering the body. For more serious conditions the family may seek the advice of a highly respected healer. Voodoo and magic are used by some families, particularly in more remote rural regions of the South. Both folk and biomedical systems are used for healing; biomedical systems are highly respected and used for serious illness (Box 3.2). Historically, African Americans have been skeptical about mainstream health care associated with their enslavement and being uninformed research subjects. With clear explanations

medical interventions are accepted by most. Most are open to health information especially when it is presented by a highly respected individual; in many cases this is the pastor of the congregation to which they belong. Essentially, within the black community, health status varies with an individual's socioeconomic status, level of education, motivation, and exposure to health-promoting information. Likewise, the health of a group of people directly impacts the overall health status of the community in which they live, and vice versa.

SUMMARY

This chapter reviewed demographic and socioeconomic trends of the African American community. Health disparities were highlighted and general cultural and linguistic characteristics were discussed. The information in this chapter, along with information presented in Chapters 2 and 7 can serve as a foundation for health professionals wanting to learn more about the cultural and linguistic preferences of African American clients.

CHAPTER THREE

Discussion Questions

- Review census data for your state and community. Compare demographic trends and patterns of African Americans with the population as a whole and with other racial groups in particular. Compare and contrast trends between rural and urban residents.

- Identify policies and programs that exist and that are needed in your catchment area to address the needs of blacks. Defend your recommendations. How can such programs/services be designed to meet the cultural and linguistical preferences of African American clients?

- Describe health disparities that exist within the African American population living in your state.

- If possible, using the information in this chapter along with Chapter 2, interview at least two African Americans to learn more about their culture, health beliefs, and expectations of health care providers. How are the responses similar and different? Based on that information how can services in your facility be modified to be more culturally and linguistically appropriate for this group of clients?

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http://www.omhrc.gov/healthy2000book/tab1.html

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African American Child Internet Resources
http://www.aachild.com

Black Colleges and Universities
http://edonline.com/cq/hbcu

Black Caucus — American Public Health Association (APHA)
1015 15th Street N.W.
Washington, DC 20005
www.apha.org

Black Parenting
Internet Resources
http://www.blackparenting.com

Black Voices
General and health-related information website
http://www.blackvoices.com

Bureau of the Census
www.census.gov

Centers for Disease Control
African Health Facts
http://www.cdc.gov/nchs/fastats/aafacts.htm

Commonwealth Fund
www.cmwf.org

Congress of National Black Churches Inc.
National Health Programs
1225 Eye St., Suite 750
Washington, DC 20005-3914
(202) 371-1091
http://www.cnbc.org

Diversity:Rx
www.diversityrx.org

Ethnomed: Cross Cultural Health Care Program
Pacific Medical Clinics
1200 Twelfth Avenue, South
Seattle, WA 98144
(206) 326-4161
http://ethnomed.org

HRSA — United States Health Workforce Personnel Factbook: 2000
http://www.ask.hrsa.gov/detail.cfm?id=BHP00003
Accessed July 25, 2001

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Medicaid and Health Insurance Coverage and Access to Care Among African Americans
Key Facts — June 2000
www.kff.org.

Minority Online Services
Educational and research-related information on minority institutions.
http://www.sciencewise.com/molis

National Center for Health Statistics
www.cdc.gov/nchs/statestatsbysexrace.htm

National Black Nurses Association
8630 Fenton Street, Suite 330
Silver Spring, MD 20910-3803
(301) 589-3200
http://www.nbna.org

National Caucus and Center of Black Aged
1424 K Street, N.W., Suite 500
Washington, DC 2005
(202) 637-8400
http://www.ncba-blackaged.org

Office of Minority Health
Healthy People 2000: Progress Review: Black Americans
www.omhrc.gov/healthy2000book/index.html

North Carolina Rural Health Research and Policy Analysis Center
Office of Rural Health Policy (ORHP)
Cartographic Archive (Maps)
Demographics of Rural America
Distribution of Non-metropolitan Black
http://www.schsr.unc.edu/research_programs/Rural_Program/maps/black.html

University Microfilms International
300 North Zeeb Drive
P.O. Box 1764
Ann Arbor, MI 48106
Black Studies: A catalogue of selected doctoral dissertation research
www.umi.com:8090/hp/Support/Research/Topics/AAStudies.htm

US Health Workforce Personnel Fact Book 2000
Health Resources Services Administration (HRSA)
www.ask.hrsa.gov
1-888-ASK-HRSA

CHAPTER FOUR

OBJECTIVES

After reading this chapter you should be able to:

- Describe demographic trends within the American Indian and Alaska Native community.

- Discuss sociocultural and economic issues impacting the health status of American Indians and Alaska Natives.

- Compare and contrast the health status of American Indians and Alaska Natives with other predominant racial groups.

- Compare and contrast the health status of American Indians and Alaska Natives in rural areas with their counterparts in urban areas.

- Highlight health disparities among American Indians and Alaska Natives.

- Demonstrate sensitivity to cultural and linguistical preferences of American Indian and Alaska Native clients.

- Compile a bibliographic resource list related to American Indians and Alaska Natives, their cultural beliefs, and health status.

AMERICAN INDIANS AND ALASKA NATIVES

OVERVIEW

This chapter provides information about American Indians and Alaska Natives, the smallest racial minority group in the United States. To be reviewed are demographic trends, socioeconomic issues, health status, and patterns of accessing health care among American Indians and Alaska Natives. General cultural and linguistic characteristics will be highlighted. The content in this chapter can be a starting point for health professionals to learn more about the beliefs and values of American Indian and Alaska Native clients.

Demographic trends

http://www.census.gov/population/www/socdemo/race/cp-3-7.html
http://www.ihs.gov

American Indians and Alaska Natives lived in North America, South America, and Central America for centuries before white men arrived. Historically, native societies also had rights to all of the land that now is the United States. With westward expansion, these societies lost communal land rights and were resettled in designated federal or state reservations, rancherias, or native villages. After World WW II, federal policy promoted resettlement in urban areas, and that is where the majority of American Indians now reside.

There is great diversity among and within the 554 federally recognized American Indian and Alaska Native tribes. A number of other tribes are recognized by individual states but not by the federal government. Each tribal society has its own culture and, in many cases, a unique language. Diversity has become even greater within this population, attributable to intertribal mixing through marriage and mixed tribal births over the past century. American Indians and Alaska Natives make up about 1% of the U.S. population; thus, are the smallest racial minority. (See Chapter 1.) Below are additional demographic trends for the American Indian and Alaska Native populations.

- The American Indian and Alaska Native population is young and growing rapidly. In 1990, the median age for Indians in the reservation states was 22.6 years, compared to 30.0 years of age for the general population (1990). (Box 4.1)

- About 70% of all American Indians and Alaska Natives live in urban areas or do not reside on a tribal reservation. (Box 4.2)

- Thirty-five states contain Indian reservations or Alaska Native entities. (Box 4.3) American Indians and Alaska Natives reside throughout the nation but are concentrated in 11 states.

- The Indian Health Service (IHS) reports that 32% of its clients are under the age of 15. This population is growing at the estimated rate of 2.7% each year.

- Elders represent a small but rapidly increasing number in the American Indian and Alaska Native populations. Nearly 166,000 elder Indians are concentrated in a few states. Nearly half of them (45%) lived in four states — Arizona (9%), California (13%), New Mexico (6%), and Oklahoma (17%).

- In 1990, elderly Indians were nearly twice as likely to be rural dwellers (48%) compared to the U.S. total elderly population (25%). Figure 4.1 displays the distribution of the Native American population in nonmetropolitan areas of the United States.

- In every age group, American Indian and Alaska Native men experience higher death rates than women.

- Elderly American Indian and Alaska Native women outnumber male counterparts in every state except New Hampshire.

Socioeconomic status
http://raceandhealth.hhs.gov

American Indians and Alaska Natives lag behind the overall U.S. population in material wealth. Reservation-based families have fewer economic and educational opportunities than the rest of U.S. society. For decades the median income for Indians on reservations or tribal land was significantly lower compared to the general population. About half of non-elderly American Indians and Alaska Natives are poor or near-poor with family incomes below 200% of the federal poverty level — twice the rate for whites.

Social and health-related problems for American Indians and Alaska Natives do not fall into neat and distinct categories. Rather the problems are interrelated and often systemic in nature. For example, on many reservations there are high rates of substance abuse, domestic violence, child and elder neglect abuse, and pervasive unemployment. Because of high rates of alcoholism and early death, grandparents and elder relatives in the extended family often must assume child-rearing responsibilities for grandchildren or nieces and nephews. Extreme financial hardship is placed on the elderly caring for grandchildren because they are denied public assistance for child support. There are no simple solutions to the multifaceted social problems on reservations. Nor are piecemeal

Box 4.1

U.S. Total Population & Indian* by Age (1990)

AGE	U.S. POPULATION	INDIAN
UNDER AGE 60	83%	92%
OVER AGE 60	17%	8%
TOTAL	100%	100%

*American Indian, Eskimo, or Aleut
http://www.aoa.dhhs.gov/AIN

Box 4.2

Rural Populations of U.S. Total and Indian* 60+ Years Old (1980 & 1990)

YEAR	U.S. TOTAL 60+	INDIAN* 60+
1980	26%	53%
1990	25%	48%

*American Indian, Eskimo, or Aleut
http://www.aoa.dhhs.gov/AIN/naepop90.html#Rural

Box 4.3

Indian Reservation States*

Alabama	Maine	Oklahoma
Alaska	Massachusetts	Oregon
Arizona	Michigan	Pennsylvania
California	Minnesota	Rhode Island
Colorado	Mississippi	South Carolina
Connecticut	Montana	South Dakota
Florida	Nebraska	Texas
Idaho	Nevada	Utah
Indiana	New Mexico	Washington
Iowa	New York	Wisconsin
Kansas	North Carolina	Wyoming
Louisiana	North Dakota	

* Considered "reservation state" if IHS has responsibilities within the state.–www.ihs.gov

Figure 4.1

DISTRIBUTION OF NONMETROPOLITAN NATIVE AMERICAN POPULATION, 1990
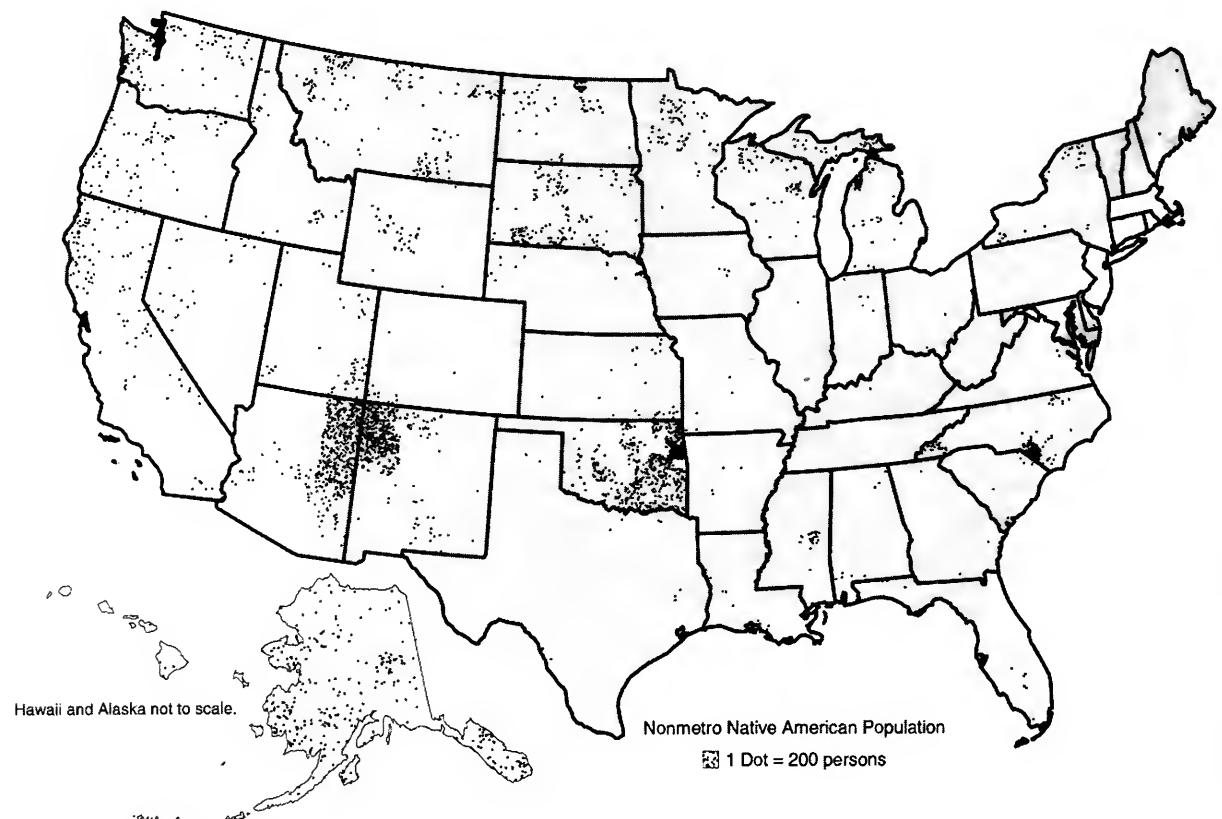
Hawaii and Alaska not to scale.

Nonmetro Native American Population

1 Dot = 200 persons

Note: Metropolitan counties are aggregated into white areas on the map.
Source: US Bureau of Census, 1990.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research,
University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS.

solutions likely to have wide or long-lasting impact for American Indian and Alaska Native communities experiencing extreme economic, geographic, and social depravation.

Health status

http://raceandhealth.hhs.gov & www.cdc.gov/nchs & www.omhrc.gov & www.cmwf.org

There are wide health disparities on many health indicators among American Indians and Alaska Natives. Overall, this population has one of the lowest life expectancy in years (Chapter 1) with an infant mortality rate about 1.5 times greater than for whites. Certain chronic health conditions are particularly high among them, in particular diabetes, tuberculosis, and cirrhosis of the liver. In fact, the highest prevalence of diabetes in the world is found among the Pima Indians of Arizona. Leading causes of death among American Indians and Alaska Natives include diabetes-related conditions, alcohol-related conditions, accidents, suicide, homicide, hypertension, and infectious diseases. Suicide — in particular, among male adolescents and young men — has escalated to epi-

Box 4.4

IHS Headquarters & Administrative Area Offices

IHS Headquarters
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4242

Aberdeen Area IHS
Federal Office Building
115 Fourth Ave. S.E.
Aberdeen, SD 57401
(605) 226-7581

Alaska Area Native Health Service
4141 Ambassador Drive
Anchorage, AK 99508-5928
(907) 729-3686

Albuquerque Area IHS
5300 Homestead Road N.E.
Albuquerque, NM 87110
(505) 248-4500

Bemidji Area IHS
522 Minnesota Ave. NW
Bemidji, MN 56601
(216) 759-3412

Billings Area IHS
2900 Fourth Ave. N.
P.O. Box 2143
Billings, MT 59103
(406) 247-7107

California Area IHS
1825 Bell St., Suite 200
Sacramento, CA 95825-1097
(916) 566-7006

Nashville Area IHS
711 Stewarts Ferry Pike
Nashville, TN 37214-2634
(615) 736-2400

Navajo Area IHS
P.O. Box 9020
Window Rock, AZ 86515-9020
FedEx Address:
Highway 264 — St. Michael's
Window Rock, AZ 86515
(520) 871-5811

Oklahoma City Area IHS
Five Corporate Plaza
3825 N.W. 56th St.
Oklahoma City, OK 73112
(405) 951-3768

Phoenix Area IHS
Two Renaissance Square
40 N. Central Ave., Suite 600
Phoenix, AZ 85004-4424
(602) 364-5039

Portland Area IHS
1220 SW Third Ave., Room 476
Portland, OR 97204-2892
(503) 326-4998

Tucson Area IHS
7900 S. J. Stock Road
Tucson, AZ 85746-7012
(520) 295-2406

www.ihs.gov

demic proportions on some reservations. National efforts are under way to help American Indian and Alaska Native communities deal with the escalating number of self-inflicted deaths among their children. Box 4.5 exhibits a culturally sensitive educational fact sheet to identify and cope with this escalating public health issue in Indian communities. (http://aihc1998.tripod.com/suicide.html)

Patterns of accessing health care

According to the University of California-Los Angeles Center for Health Policy Research (http://www.healthpolicy.ucla.edu/publications) and the Henry J. Kaiser Family Foundation (www.kff.org), data on health insurance coverage and access to care for the American Indian and Alaska Native population are limited because of these populations' small numbers and wide geographic dispersion. To reiterate, only members of federally recognized tribes can use Indian Health Service (IHS). Medicaid becomes an important source of health coverage because a high proportion of non-elderly American Indians and Alaska Natives are poor or near poor. Medicaid and other public programs are the primary source of coverage for about 25% of this population. In 1997, only 20% of American Indians and Alaska Natives reported having access to IHS. Among those using IHS, half reported having Medicare, Medicaid, or private coverage.

The *Kaiser/Commonwealth Fund 1997 National Survey of Health Insurance* reports the rate of job-based health insurance coverage among American Indians and Alaska Natives is significantly lower (<50%) compared to whites (72%). American Indians and Alaska Natives have fewer job opportunities that are likely to offer health care benefits; thus, their access to employer-sponsored coverage is limited. They did not experience the same gains in employer-based coverage from improvements in the nation's economy over the past decade as other groups have. For American Indians and Alaska Natives with very low incomes, purchasing private insurance or job-based coverage (if available) poses an extreme financial hardship. Of the uninsured American Indians and Alaska Natives, 35% report they do not have a usual source of care. This rate is three times greater than for those who have some form of health insurance coverage or have access to the IHS.

Of the uninsured American Indians and Alaska Natives, about 30% do not meet a minimal standard of routine physician care (defined as an annual visit to primary care provider for children under 6 and for adults who are in fair or poor health; biennial visits for older children and healthier adults). Among those with health insurance, that rate is reduced by 50%. American Indians and Alaska Natives who are covered only through the IHS are more likely to have a usual source of care than are the uninsured. However, those who are eligible for IHS are less likely to have obtained the minimum number of doctor visits for their age and health status compared to those with health insurance coverage.

Indian Health Service (IHS)
www.ihs.gov

The IHS is a federally dedicated provider of care for American Indians and Alaska Natives. An agency within the DHHS, the IHS emerged from a government-to-government relationship between the federal government and Indian tribes in 1787 (Article I, Section 8 of the Constitution). Since then, IHS has evolved with numerous treaties, laws, Supreme Court decisions, and executive orders. The IHS provides services to approximately 1.5 million individuals who are registered members of a federally recognized tribe. People who belong to a tribe that is recognized by only a state (and not the federal government) are not eligible for IHS. With a few exceptions, IHS clinics and hospitals are situated on reservations primarily located in rural areas. Because a high proportion of American Indians and Alaska Natives live in urban areas, accessing care from IHS providers often involves traveling to the reservation (often located in very remote areas) where the client is registered as a tribal member. Wide dispersion of American Indians and Alaska Natives on reservations located in 35 states, coupled with increasing numbers who migrate to urban areas, poses a major challenge for the IHS in achieving its mission.

The IHS Headquarters, located in Rockville, MD, oversees the following activities:

- Providing technical assistance and monitoring area and field activities.

- Formulating statistical information and budgets.

- Planning, implementing, managing, and evaluating operational programs and policies.

- Allocating financial, material, and human resources to area offices.

- Maintaining communications with the Department of Health and Human Services and the U.S. Congress.

The IHS has 12 regional administrative area offices that oversee local service units (e.g., hospitals, clinics) and manage programs under contract by individual tribes as authorized by the Indian Self-Determination Act (P.L. 93-638). (Box 4.4) The IHS area offices are responsible for all IHS programs within their geographical region (budget, operations, personnel, property management, program planning and implementation, tribal affairs, community development, statistical monitoring, grants and contracts management, and facilitation of environmental health programs). The IHS area offices are decentralized into 127 basic administrative units (service units), usually defined by Indian reservation(s) or tribe(s) to which services are provided. A service unit may include one or more satellite facilities and/or field health stations. IHS has a system of inpatient and ambulatory care facilities including 41 IHS hospitals ranging in size from 11 to 170 beds, along with three medical centers located in Phoenix; Gallup, NM; and Anchorage, AK.

To the extent of the resources available, IHS provides a full range of preventive care, primary medical care (hospital and ambulatory care), community health, alcoholism treatment programs, and rehabilitative services. Either IHS staff or non-IHS contractors

Box 4. 5

EXEMPLAR: Fact Sheet — Suicide Prevention "When you reach out, you're not alone."

The American Indian most inclined toward a completed suicide has the following social characteristics:

- He is often a male between 15 and 24 years of age.
- He is single.
- He is under the influence of alcohol just before his suicide attempt.
- He has lived with a number of ineffective or inappropriate parental substitutes because of familial disruption.
- He has spent time in boarding schools and has been moved from one to another.
- He has been raised by caretakers who have come into conflict with the law.
- He often has been jailed at an early age.
- He has experienced an emotional loss, such as divorce, desertion, or death in the family.
- He has experienced a past loss through violence of someone to whom he felt attached.

Ten preventive steps:

- Listen. The first thing a patient in a mental crisis needs is someone who will listen and really hear what he is saying. Every effort should be made to understand the feelings behind the words.

- Evaluate the seriousness of the suicidal patient's feelings. All suicidal talk should be taken seriously. If the patient has made definite plans, the problem is apt to be more acute than when his thinking is less definite.

- Evaluate the intensity or severity of the emotional disturbance. It is possible that the patient may be extremely upset but not suicidal. If a person has been depressed and then becomes agitated and moves about restlessly, it is cause for alarm.

- Take every complaint and feeling the patient expresses seriously.

- Do not dismiss or undervalue what the person is saying. In some instances the person may express his difficulty in a low-key manner.

Box 4. 5 - continued

Ten preventive steps (continued):

- Do not be afraid to ask directly if the person has entertained thoughts of suicide. Suicide may be suggested but not specifically mentioned in the crisis period. Experience shows that harm is rarely done by inquiring directly into the person's thoughts. In fact, the individual welcomes it and is glad the counselor enables him to open up and bring it out.

- Do not be misled by the suicidal person's comments that he is all right and is past the crisis. Often the suicidal person will feel initial relief after talking of suicide, but many times on second thought he will try to cover it up. The same thinking will come back later, however. Follow-up is crucial to ensure a good treatment program.

- Be affirmative but supportive. Strong, stable guideposts are extremely necessary in the life of a distressed individual.

- Provide him with strength by giving him the impression that you know what you are doing and that you intend to do everything possible to prevent him from taking his life.

- Evaluate the resources available The person may have both inner psychological resources, such as various mechanisms for rationalization and intellectualization, which can be strengthened and supported, and outer resources such as ministers, tribal elders, relatives, and others whom one can call in. If these are absent, the problem is more serious. Careful observation and support are necessary.

- Act specifically. Do something tangible; that is, give the patient something definite to hang onto, such as arranging for him to see someone else. Nothing is more frustrating to the patient than to leave the counselor's office and feel as though he received nothing from the interview.

- Don't be afraid to ask for assistance and consultation. Call upon whomever is needed, depending upon the severity of the case. Don't try to handle everything alone. Convey an attitude of firmness and composure to the suicidal person so he will feel that something realistic and appropriate is being done to help him.

SOURCE: American Indian Health Center — http://aihc1998.tripod.com/suicide.html

provide highly specialized medical and rehabilitative care. In communities where IHS does not have facilities or is not equipped to provide a needed service, it contracts with area hospitals, state and local health agencies, tribal health institutions, and private citizens to do so. Clinical staff within IHS include physicians, dentists, nurses, pharmacists, therapists, dietitians, laboratory and radiology technicians, and medical and dental assistants. Community health medics (IHS-trained physician assistants), nurse practitioners, and nurse-midwives complete the clinical team. Additionally, IHS is engaged in the following activities:

- Assist Indian tribes in developing local health programs through activities such as health management training, technical assistance, and human resource development.

- Assist Indian tribes in coordinating health planning and obtaining/using health resources available through federal, state, and local programs; operating comprehensive health care services; and evaluating programs.

- Provide comprehensive health care services, including hospital and ambulatory medical care, preventive and rehabilitative services, and development of community sanitation facilities.

- Serve as the principal federal advocate for Indians to ensure comprehensive health services for American Indian and Alaska Native people.

The IHS has several initiatives that target vulnerable and at-risk Native American and Alaska Native populations, among others, the Maternal and Child Health, Otitis Media, Acquired Immune Deficiency Syndrome (AIDS), Aging Services, and Information Management initiatives. Each of these will be examined in more detail in the next section.

Maternal and Child Health Initiative

The family is recognized as the traditional and most important basic social unit in American Indian and Alaska Native communities. The IHS is sensitive to their family-oriented beliefs and promotes family-centered care in all facilities providing maternal and child health (IHS-MCH) services. Historically, high rates of infant morbidity and post-neonatal mortality in this population led to an emphasis on early and adequate prenatal care for all pregnant women along with ongoing postpartum and well-child care. Prenatal and postnatal education help mothers and fathers develop healthy parenting skills, understand normal growth and development, and manage common childhood health problems. Challenges associated with high teen pregnancy rates, high infant mortality rates related to accidents, and the complex needs of abused and neglected children mandate interagency cooperation on the state level as well as on the reservation. The MCH program includes family planning and cervical- and breast-cancer detection programs.

Otitis Media Initiative

Otitis media is a disease of the middle ear that may cause hearing loss. Not long ago, otitis media posed more health problems to Indian people than even tuberculosis. Subsequently, IHS focused on reducing the incidence of chronic otitis media comparable to that of the non-Indian population. This was accomplished by IHS with intense preven-

tion programs, treatment of acute and chronic cases, and rehabilitation services. Communication disorders and language deficiencies are treated at select IHS facilities, along with specialized care for children with disfigured faces, learning disabilities, deafness, and other related health problems. Provision of hearing aids by IHS has helped patients of all ages regain communication and social abilities.

Acquired Immune Deficiency Syndrome (AIDS) Initiative

The IHS has developed a comprehensive AIDS initiative in response to the potential risk of a human immunodeficiency virus (HIV) epidemic among American Indians and Alaska Natives. The initiative began in 1987 with the establishment of AIDS-related performance standards for resource identification, disease reporting, seroprevalence testing, public education, risk reduction, patient counseling, and clinical care. The IHS, along with Centers for Disease Control, established a national seroprevalence program to determine the extent of HIV infection in the American Indian and Alaska Native communities.

Aging Services Initiative

American Indians and Alaska Natives are living longer because of improved nutrition, health care, and lifestyle changes. With the growing number of elderly who are living on remote reservations there are demands for gerontologic health and social services, ambulatory and home care programs, and alternative living arrangements. The IHS is expanding programs that are of primary concern for the elderly.

Information Management System Initiative

American Indians and Alaska Natives are increasingly mobile, making accurate record-keeping difficult. The IHS has an extensive health database on this diverse population that can track clients' medical histories throughout the course of lives. For the IHS Resource and Patient Management System (IHS-RPMS), staff enter data at more than 200 IHS tribal health facilities across the United States. A key element of the RPMS is the Patient Care Component (IHS-PCC), which provides for the confidential collection, storage, and output of a broad range of health data from inpatient, outpatient, and field services. Other applications include patient registration and administration, pharmacy services, immunization tracking, dental services, clinic scheduling, contract health services, quality assurance, and research purposes. Statistical reports are generated at the IHS Data Center in Albuquerque, NM. This comprehensive database enables the IHS, tribal administrators, and health planners to identify and track particular problems facing the population in a specific service area. Subsequently, appropriate strategies and services can be formulated to better meet the needs of a targeted community.

Recruitment, retention, and education of health professionals
www.statehealthfacts.kff.org

American Indians and Alaska Natives are significantly underrepresented in the health professions. They make up less than 1% of nation's population, but not even this

very small proportion is equitably represented in this field. In 1999, for example, only 0.1% of the nonfederal workforce included American Indians and Alaska Natives. However, since the IHS is a federal entity, the previous statistic likely does not adequately reflect the true proportion of Native American and Alaska Native physicians. Considering the diversity within this population (more than 500 tribes), it is unlikely that there is an equitable representation of physicians and nurses from each tribe. An adequate supply as well as equitable geographic distribution of American Indians and Alaska Natives is essential to improve the health status of this population. (*HRSA — U.S. Health Workforce Personnel Fact Book 2000*, www.ask.hrsa.gov) A cadre of American Indian and Alaska Native health clinicians, educators and researchers also are needed to serve as role models and strategists in recruitment and retention programs targeting minority students. (www.aaip.com) (See Chapter 1, Chapter 7, Appendix C.)

The IHS has several initiatives in place for recruiting, retaining, and educating health professionals and paraprofessionals to better meet the needs of American Indians and Alaska Natives. (See Chapter 1.) The National Health Service Corps (NHSC) in particular works closely with IHS in educating and placing physicians, nurses, and other types of health professionals within its system. Incentives exist for American Indian and Alaska Native nurses to seek additional education through the Nurse Education Center for Indians (NECI), allowing licensed practical nurses to become registered nurses (associate degree–prepared or bachelor degree–prepared) and for graduate study (master's degree).

Allied and auxiliary health personnel are vital in IHS' provision of health care for American Indians and Alaska Natives. These individuals augment the work of health professionals and make services more accessible to American Indians and Alaska Natives. Career and on-the-job training is made available by the IHS for community health representatives, community health aides, health records technicians, dental assistants, optometric assistants, mental health workers, medical social work associates, food service supervisors and nutrition aides, nursing assistants, and medical records clerks.

The *Community Health Aide Training Program* was developed in Alaska to train selected village residents in primary health care. Remote villages depended on the community health aide (CHA) for first-line primary health care and as the initial responder for emergency care. Because of its success, the CHA program was implemented on some other reservations. Preventive health services provided by Native Americans who have completed the requirements for the CHA are coordinated with native health corporations, the state department of health, and the IHS. Native CHAs are important links with health care providers and individuals in their communities.

Mental health workers are American Indians and Alaska Natives who are knowledgeable about psychological and social aspects of the people they serve. They are highly sensitive to the needs of the communities in which they work and promote understanding between the American Indian or Alaska Native patient and non-Indian medical providers. They assist psychiatrists, psychologists, psychiatric social workers, and other

mental health professionals in providing mental health services in the community, schools, hospitals, and health centers.

Nutrition and dietetics assistants attend a training program in Santa Fe, NM, and assist in IHS or tribe-operated hospitals and facilities. *Optometric assistants* deliver eye care at the IHS optometry and ophthalmology clinics and provide optical support and direct patient care assistance. Where direct eye care is not available, individuals are trained as eye care coordinators who arrange for contract optician support for the tribe. *Dental assistants* assist in delivering preventive services and enhance existing IHS dental services. Essentially, IHS paraprofessionals reach out to their communities and are an important link in the provision of holistic care to Native American and Alaska Native families.

Cultural & linguistical characteristics
http://aihc1998.tripod.com

American Indian and Alaska Native tribes are highly diverse culturally and linguistically. The next few sections provide general background information about these populations. To reiterate, the information included in the next few paragraphs *is not absolute!* Rather, it is a starting point for health professionals to learn more about the cultural and linguistic preferences of clients who are of American Indian or Alaska Native origins. Boxes 4.6 and 4.7 highlight life transitions and associated health beliefs held by some American Indians and Alaska Natives.

Ethnic identity

The culture of American Indians and Alaska Natives varies among tribes, clans or societies, and geographical area. Most refer to themselves by tribal name, for example, Ute, Seminole, Crow, Cheyenne, Lakota. Older individuals often prefer the title "Indian people" to that of "American Indian" or "Native American."

Social organization

For most American Indians and Alaska Natives, family is of utmost importance. There are tribal variations in social organizations and kinship structures, but these usually center around extended family networks. Some societies have matrilineal structures in which women are the heart of the family. Others have patrilineage structures in which descent is reckoned through males; that is, father, grandfather, great-grand father, etc. Some societies refer to "cousins" in their clan as brothers or sisters while aunts and uncles may be referred to as "mother" and "father." The designated family spokesperson will vary by a tribe's kinship structure.

Sharing is a way of redistributing wealth, and among most societies, giving is highly valued. Some tribes hold celebrations in which individuals give prized possessions to others and respected tribal members share their wealth with other family members.

Gender roles differ within tribes and by age. For instance, in matrilineal societies women (and/or their brothers) make important decisions related to the clan and its activities. In these societies males engage in rituals to protect the family and ensure the

Box 4.6

Select Native American & Alaska Native Life Transitions & Health Behaviors*

Childbearing

Pregnancy care and labor practices vary among tribes. Mother or other female relatives often are highly involved during pregnancy and may attend a normal delivery. Pain control could include meditation, self control, and use of indigenous herbs or plants. IHS maternal health programs accepted as an integral component of perinatal care. Traditionally, stoicism encouraged and expected. The role of father varies with culture; he may practice certain ritual avoidances (e.g., hunting, eating meat) immediately following birth and until the baby's cord falls off. Vaginal delivery preferred; cesarian section feared based on history of unwanted sterilizations. Breastfeeding usually augmented with bottle feeding. Some cultures advocate that mother and infant rest and stay indoors for 20 days or until cord falls off. The umbilical cord remnant may have spiritual significance and ritualistic family activities may be associated with that event. New mothers are given strengthening foods that vary by tribe and region. Native American babies have a darkly pigmented area on their lower back above the buttocks (Mongolian spot) and should not be confused with child abuse. Circumcision is not a usual practice in most societies.

Child rearing

Children respect their elders. They are encouraged to take pride in the tribal culture, develop their natural talents, and be responsible to the community, tribe, and family. Children are encouraged to seek help within the family and often expected to assume caregiving responsibilities for family elders.

Serious & terminal illness

Privacy and personal autonomy valued; thus, it is unlikely that problems will be discussed. Illness may be perceived as a "family matter"; hence, immediate and extended family (clan) are told about condition of patient, test results, and prognosis; family may want to spend time together during these events. Some cultures prefer not to openly discuss terminal status and do-not-resuscitate (DNR) codes because negative thoughts might hasten the inevitable death. Other cultures use information to make appropriate information. Children are not to impose their own wishes on parents' end-of-life decision.

Source: Geissler, 1994: hipson et.al., 1996 Spector, 1996

Box 4.6 (continued)

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Select Native American & Alaska Native Life Transitions & Health Behaviors (continued)

Death & dying

Arrange for family meetings to discuss condition, course of treatment, palliative care, and end-of-life decisions for the sick person. Some tribes avoid contact with the dying person while others prefer being in the same room around the clock. Family might include immediate as well as extended kinship networks. If family feels comfortable and welcome, even while death is imminent, the atmosphere may be jovial with eating, joking, playing games, and singing. Small children may be included. Although outcome is tacitly recognized, positive attitude is sustained and family may avoid discussing impending death. Some cultures value demonstrating a positive attitude and feel that sadness and mourning should be done in private — away from the patient. Some prefer to have an open window in the room of the dying patient or to orient the person's body toward a cardinal direction before death. After death occurs, the family may hug, touch, sing, and stay close to the deceased person. Wailing, shrieking, and other outward signs of grieving may also occur. Family may bring indigenous healers to attend to dying person's spiritual health.

Preferred place for death varies by culture. Those preferring to avoid contact with the deceased may prefer a hospital setting;. End-of-life decisions may include concerns for naturalness and comfort. Women in the family may prepare and dress the body or use sweet grass smoke for purification. Some families prefer to take the body home the night before burial to be cleansed and dressed and to spend the last night on earth with their loved one. Others prefer the body to rest at the place of death for 36 hours, at which time the soul departs for the spiritual realm. Other cultures avoid contact with the deceased person and his/her possessions. Some families want all of the deceased's possessions collected including hair and nail pairings.

Generally, organ donations and autopsies are not desired. If opportunity for frank and open discussion occurs, health care provider should distinguish fact from probability, seek consultation with family members, relatives, and sometimes healers, and indicate that consent and refusal are equally valued.

* Source: Kramer, 1996; Garrett, 1991; Hepburn & Reed, 1995.

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Box 4.7

EXEMPLAR: Select Native American/Alaska Native Health Beliefs

healers	Traditional medicine often used to manage symptoms and/or is combined with Western medicine. Healing practices vary with the disease and individual's lifestyle (e.g., traditional, assimilated).
pain	Tends to be undertreated in Native Americans. Complains of pain in general terms — e.g., "I don't feel so good" or "Something doesn't feel right." May report pain to family member, who in turn reports this to caregiver. If reported pain goes untreated, patient unlikely to repeat request.
dyspnea	Reported subtly with expressions such as "The air is heavy" or "The air is not right."
nausea & vomiting	May be a source of embarrassment.
constipation & diarrhea	Reported with modesty and matter-of-fact manner.
fatigue	May reflect physical and psychosocial problems. Generally, a high level of activity is maintained in spite of poor health or functional impairment.
depression	Depression acknowledged and often reported metaphorically — "heaviness/emptiness in my heart" or "out of balance with nature."

Source: Geissler, 1994; 1996 Spector, 1996

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well-being of their community. In respect to alternative sexual preferences, in some societies homosexuality is better accepted than others. Likewise, some communities are reluctant to even talk about HIV/AIDS out of fear that this in and of itself predisposes family members to contract the disease.

Elders are highly respected by most American Indians and Alaska Natives. The status of "elder" is acknowledged by family members when an individual begins to physically deteriorate and/or when he or she assumes a certain role such as counseling, teaching, or becoming a grandparent. Generally, this population does not try to conceal physical signs of aging, such as covering gray hair. Self discipline, self control, and positive attitude toward living are expected behaviors for elders. Home care is preferred to placing a family elder in an institution. Even though such services may be greatly needed, skilled nursing facilities are few and far between on reservations. Autonomy is highly valued and a spouse generally does not make an important decision for his or her partner. Usually individuals speak for themselves, but family members may speak on behalf

of someone who is seriously ill. When someone is ill, the designated caregiver will vary from one society to another. Oftentimes children and grandchildren are expected to assume caregiving responsibilities for family elders. Children are expected to respect elders, take pride in the tribal culture and develop their natural talents. While autonomy is valued, independence is tempered by responsibility to the family, tribe, and community. Children are not encouraged to seek help outside of the family or to impose their wishes on elder parents — for instance, regarding end-of-life decisions.

Communication patterns and preferences

Almost all American Indians and Alaska Natives speak English, but a high proportion are functionally illiterate. However, it is not unusual for elders living on reservations to still speak their native language. In day-to-day conversations, American Indians' and Alaska Natives' explanations are eloquently constructed, and the speaker provides precise meaning through metaphors and examples. For example, when asked about a health problem, the individual may describe symptoms in terms of a particular animal's behavior or injury. Long pauses are part of a conversation. It is important *not to interrupt* the speaker until he or she is finished speaking. Listening is highly valued. Loudness is associated with aggression. When asking a question that requires more than a "yes" or "no" answer, be patient and expect careful consideration on the part of the person before responding. Rushing an elderly person is considered to be especially disrespectful. Respect is communicated by avoiding direct eye contact and maintaining an appropriate distance. A common mistake that health professionals make when communicating with this population is asking too many questions too early, as in the case of an admission assessment. This direct approach is considered to be aggressive by some American Indians and Alaska Natives. Outsiders, in this case health professionals, must take into consideration American Indians' and Alaska Natives' cultural boundaries when conversing with these clients. In brief, regardless of the person's age, when making a request, explain politely why it is needed. Then allow adequate time for the individual to become comfortable before proceeding with other questions and directives.

Time orientation

American Indians and Alaska Natives (Indian people) tend to be past-oriented, but this will vary depending on a person's level of education and participation in the dominant society. Generally, the concept of "time" is perceived as relative — flowing with the sequence of natural events and seasons of the year. For instance, traditional people living on the reservation may get up when the sun rises and retire soon after it sets. American Indians and Alaska Natives usually do not "watch the clock." "Indian Time" infers "when everyone gets there," and one does things as they need to be done. For instance, a community meeting may be scheduled to start at 1 p.m., but attendees will arrive as near to that time as it fits their individual schedules. Thus, it is not unusual for the meeting to "officially" begin an hour or two after it was originally scheduled. No one seems to be bothered by this occurrence except future-oriented Anglo-Americans. Indian people's flexible perception of time often conflicts with rigidly scheduled appointments. Essentially, Indian people live each day as it comes; plans for tomorrow are left until the

future becomes the present. To have great patience and to wait is considered a good human quality among American Indians and Alaska Natives.

Control of the environment

Traditionally, American Indian and Alaska Native societies believe that mankind should live in balance with nature. Humans are stewards of the planet and Mother Earth. If mankind accepts the responsibility of living harmoniously with nature, nature produces abundantly — for all creatures to share. However, if humans do not respect and fulfill this responsibility, illness, natural disasters, and famine will prevail. The world view of humans living in harmony with nature also is reflected in the care-seeking behaviors of American Indians or Alaska Natives.

Health beliefs and practices

Generally, American Indians and Alaska Natives hold traditional holistic beliefs about remaining healthy and avoiding illness. Traditionally, these populations engaged in health-promoting behaviors by enhancing physical stamina (e.g., running, aerobic exercising), relaxation (e.g., meditation), cleansing (e.g., sweats, smudging with smoke from a sacred plant), and participating in rituals to restore harmony with nature and the community. Prayer and religious ceremonies are important in sustaining the health of the individual, family, and community. Those subscribing to Western medicine may desire health screening. However, those adhering to traditional medicine may not recognize the notion of "silent disease." Hence, they may be reluctant to participate in such practices unless first educated about the value of screening and early diagnosis of a health problem. Beliefs about causes for illness and genetic defects vary among individuals and whether they adhere to traditional/cultural healing or Western medicine. As mentioned earlier, some attribute illnesses to not living harmoniously with nature while others attribute it to violations of socially proscribed behaviors. As for the cause of mental illness, some attribute the symptoms to interference by a deceased relative ("ghost") or breaking a cultural taboo. Often the expected role for the sick person among Indian people is to remain quiet and stoic. (http://www.uchsc.edu/ai/ncaianmhr)

American Indians and Alaska Natives historically had a complex and extensive healing system, with an impressive repertoire of ethno-pharmaceutical medicinals. In the past century Congress passed legislation that banned their traditional religion. This law remained in effect until 1979 with the Indian Freedom of Religion Act. Native roots and herbs continue to be used by many Indian people to treat common health problems (e.g., muscle aches, upper respiratory infection, influenza, gastrointestinal upsets) along with purification rituals, such as with smoke from sweet grass and/or use of the sweat lodge.

Traditional "Indian medicine" treats body and spirit (holistic), is wellness-focused, and generally uses visionary diagnoses. Ritual objects may be used in traditional healing ceremonies such as feathers, prayer staffs, amulets, or a personal belonging. Conversely, Western medicine is symptom- and illness-oriented, is organ-/system-specific, and relies on technical diagnostic measures. Among Native Americans and Alaska Natives, invasive procedures (e.g., biotechnology, surgery, chemotherapeutics) are deemed to be inter-

ventions of last resort; thus, they are reluctantly sought. Such procedures are believed to interfere with humans living in harmony with the environment.

After many decades of extensive education by the IHS, many American Indians and Alaska Natives make distinctions between a problem that requires an indigenous healer versus one best treated by Western medicine. It is, however, not unusual for both approaches to be used simultaneously. Most people in these populations consider the two paradigms complementary in nature. Therefore, when traditional healing is part of the treatment plan, health professionals should discuss with the healer what is expected of them during the ceremony. For example, can outsiders be present in the room? Do certain objects in the room need to be moved or removed? Are other resources necessary for the ceremony? Anglo-Americans are quite fascinated by "Indian medicine" and have many questions about traditional healing practices. Lack of trust inhibits many natives from sharing information about traditional healing rituals with health professionals.

Do not expect an American Indian or Alaska Native to openly discuss this topic with an outsider. Nonetheless, health professionals should expect that most use some traditional medicine practices to remain healthy and when they become ill.

SUMMARY

This chapter reviewed demographic and socioeconomic trends among American Indians and Alaska Natives. Health disparities were highlighted and general cultural and linguistic characteristics were discussed. The role and scope of the Indian Health Service was examined. The information in this chapter, along with information presented in chapters 2 and 7, can serve as a foundation for health professionals desiring to learn more about the cultural and linguistical preferences of American Indians and Alaska Natives.

CHAPTER FOUR

Discussion Questions

- Review census data for your state and community. Identify and describe characteristics of reservations (if any) in your state. Describe the population. Learn about IHS programs that exist within your state and how your institution interfaces with these.

- Compare demographic trends and patterns of Native Americans and/or Alaska Natives with the population as a whole and with other racial groups in particular. Compare and contrast trends among rural residents with those of urban residents.

- Identify policies and programs that exist or are needed in your catchment area to address the needs of Native Americans and Alaska Natives. How can such programs/services be designed to meet the cultural and linguistical preferences of these clients?

- Describe health disparities that exist within the Native American and/or Alaska Native populations in your state.

- If possible, using the information in this chapter along with Chapter 2, interview at least two Native Americans and/or Alaska Natives to learn more about their culture, health beliefs, and expectations of health care providers. How are the responses similar or different? Based on that information, how can services in your facility be modified to be more culturally and linguistically appropriate for this group of clients?

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http://www.hanksville.org/sand

American Indian and Alaska Native Research and Education resources
http://www.ldb.org/vl/geo/america/indi_hr.htm

American Indian and Alaska Native
http://www.ldb.org/vl/geo/america/indi_hn.htm

American Indian and Alaska Native Issues
http://www.indianz.com

American Indian Health Central
http://aihc1998.tripod.com

American Indian Health Resources
http://www.ldb.org/vl/geo/america/2usa-ind.htm

American Indian Health Council
http://aihc1998.tripod.com

Association of Indian Physicians (AAIP)
www.aaip.com

Commonwealth Fund
www.cmwf.org

EPA — American Indian Environmental Office
http://www.epa.gov/indian/index.htm

Ethno-Med: Cross Cultural Health Care Program
Pacific Medical Clinics
1200 12th Ave. S.
Seattle, WA 98144
(206) 326-4161
http://ethnomed.org

Healthy Nations Initiative
Sponsor: Robert Wood Johnson Foundation
http://www.uchsc.edu/sm/hnp/index.htm

Indian Health Service (IHS)
http://www.ihs.gov

Indians into Medicine (INMED) Program
University of North Dakota
School of Medicine
Grand Forks, ND 58202-9037
(701) 777-3037
http://www.med.und.nodak.edu/depts/inmed/home.htm

Kaiser Foundation
www.kff.org

National Center for American Indian and Alaska Native Mental Health Research
University of Colorado Denver: Health Sciences Center
http://www.uchsc.edu/sm/ncaianmhr

National Center for Health Statistics
http://www.cdc.gov/nchs

National Health Service Corps
http://www.bphc.hrsa.dhhs.gov/nhsc/Pages/toc.htm

National Indian Council on Aging
http://www.nicoa.org

North Carolina Rural Health Research and Policy Analysis Center
Office of Rural Health Policy (ORHP)
Cartographic archive (maps)
Demographics of rural America
Distribution of non-metropolitan Native American population
http://www.schsr.unc.edu/research_programs/Rural_Program/maps/natamer.html

Pan American Health Organization
http://www.paho.org

U.S. Department of Agriculture
Animal and Plant Inspection Services: Partnerships Across Nations
http://www.aphis.usda.gov

CHAPTER FIVE

OBJECTIVES

After reading this chapter you should be able to:

- Describe the ethnic makeup of the Hawaiian and Pacific Islands.

- Analyze generational patterns of Asians in relation to their acculturation into mainstream society.

- Discuss sociocultural and economic issues impacting the health status of Asian Americans and Pacific Islanders.

- Describe demographic trends within the Asian American and Pacific Islander community.

- Compare and contrast the health status of AAPIs with other racial groups in the U.S.

- Compare cultural preferences and health beliefs of predominant Asian subgroups living in the U.S., specifically, Cambodians (Khmer), Chinese (Chinese Americans), Filipinos, Hmong ("human beings"), Japanese, Koreans, and Vietnamese.

- Highlight health disparities among specific Asian American and Pacific Islander ethnic subgroups in rural and in urban areas.

- Develop awareness regarding the rural nature of the Hawaiian Islands and the associated challenges residents face in accessing health care.

- Identify partnership initiatives between the federal government and the Hawaii state government that focus on the health needs of Native Hawaiians.

- Compile a bibliographic resource list related to AAPIs, their cultural beliefs and health status.

CHAPTER 5

ASIAN AMERICAN & PACIFIC ISLANDERS (AAPIS)

OVERVIEW

This chapter provides information about AAPIs, an ethnically, culturally and linguistically diverse population. As a group, they are the third largest racial minority in our nation. To be reviewed are demographic trends, socioeconomic issues, health status, and patterns of accessing health care within the AAPI community. General cultural and linguistic characteristics for seven of the larger ethnic groups will be examined in some detail, specifically Cambodian (Khmer), Chinese, Filipino, Hmong, Japanese, Koreans, and Vietnamese. The content herein can serve as a starting place for health professionals to learn more about the beliefs and values of clients who have Asian and Pacific Island origins.

Demographic trends

Asian Americans and Pacific Islanders are a a rapidly growing segment of the population, composing nearly 4% of the total U.S. population. (Chapter 1) They are an extremely heterogenous population, having wide diversity in their ethnic makeup, language, cultural beliefs, socioeconomic status, and degree of assimilation into mainstream American society. In recent years there have been a high number of immigrants from various Asian nations coming to this country. Some come as refugees to escape political, economic, and social unrest while others come to join U.S.-based relatives. A significant number of recent emigrés are settling in rural areas of midwestern states. Figure 5.1 displays the distribution of the Asian population in nonmetropolitan areas of the United States. (http://www.census.gov/population/www/socdemo/race/cp-3-7.html)

Ethnic diversity among the Asian population

The AAPI population comprises more than 30 ethnic groups and generational subgroups (e.g., fourth-, third-, second- and first-generation American Asians; the children of first-generation emigrants/refugees who have been in the U.S. anywhere from a few weeks to several years). Some AAPI subpopulations are as different from each other as they are from other ethnic groups. Generally, recent immigrants have stronger ties to their Asian culture while longtime residents tend to be quite "Americanized." Among

Figure 5.1 DISTRIBUTION OF NONMETROPOLITAN ASIAN POPULATION, 1990
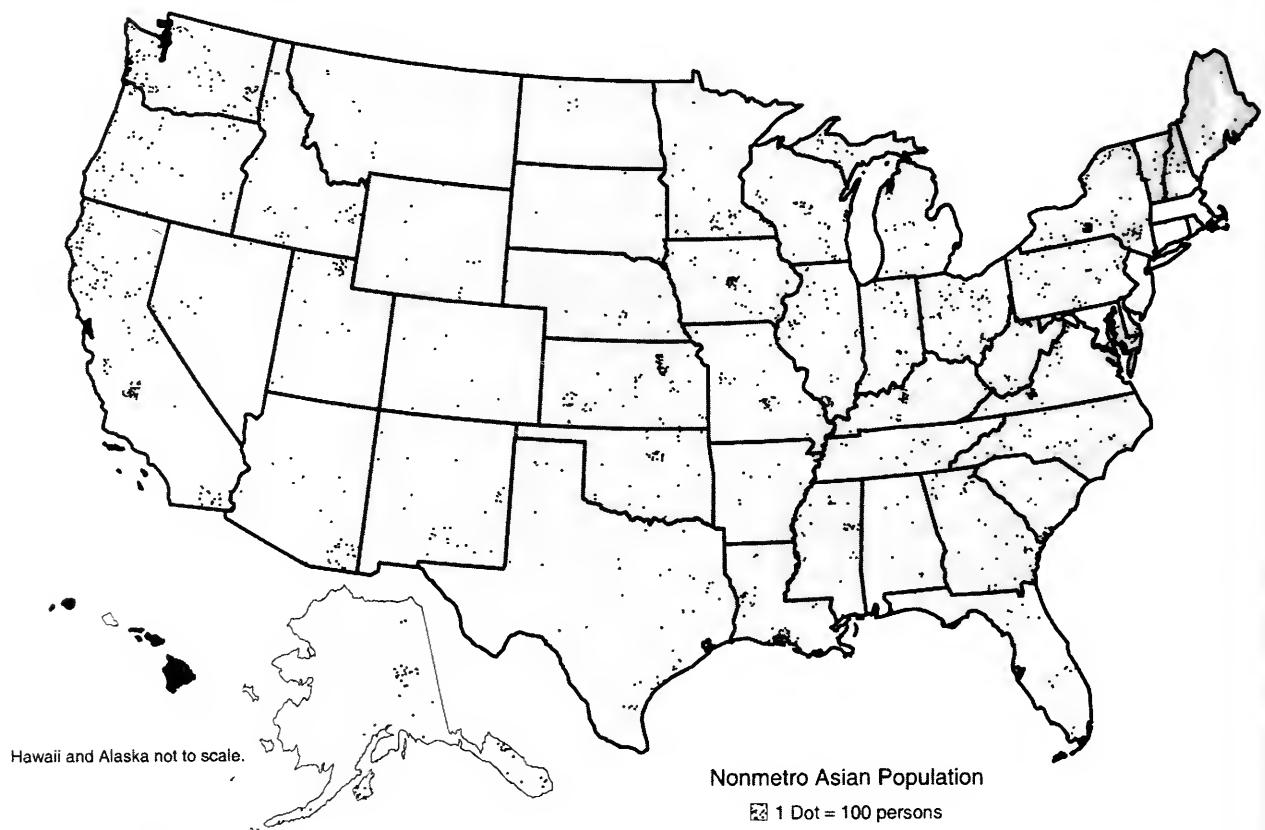
Hawaii and Alaska not to scale.

Nonmetro Asian Population

▨ 1 Dot = 100 persons

Note: Metropolitan counties are aggregated into white areas on the map.
Source: US Bureau of Census, 1990.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research,
University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS.

immigrants, younger people and children tend to assimilate more quickly than their eld-ers. Nations from which Asians originate include China, Philippine Islands, Cambodia (Khmer), Hmongs, Japan, Korea, Vietnam, Laos, Thailand, and countries in South Asia including India, Pakistan, Bangladesh, Sri Lanka, and Nepal. While earlier generations of Asians settled in more populated areas, a significant number of recent arrivals are moving into rural areas of the midwest to work in the meat-packing industry or as sea-sonal and migrant agricultural workers. (Figure 5.1) According to Census 2000, Nevada had the largest influx of Asians. (http://www.omhrc.gov/ctg/pacificislanders.pdf)

Degree of acculturation is significant because it is a factor in an Asian's health care practices and his or her ability to navigate through the American health system. Access to care is especially problematic for Asians who have settled in rural areas. As a group they have more recent immigrant status with fewer years of formal education. Original-ly, many left their country to escape political and religious persecution. Many are leaving their country to join relatives who arrived in the U.S. at an earlier time

Native Hawaiians and Pacific Islanders

Pacific Islanders comprise two categorical groups: *Polynesians* (Native Hawaiians, Samoans, Tongans, Maoris, Cook Islanders, Tahitians, Rapa Nui) and *Micronesians* (Marshall Islanders, Paulauans, Chamarros, Northern Mariana Islanders, Carolinians, Melanesians, Fijians). These ethnic groups reside in the *United States-Associated Pacific Flag Territories* (American Samoa, Territory of Guam, Commonwealth of the Northern Marina Islands [CNMI]) and the *Freely Associated States* (Micronesia [Truk 'Chuck', Kosrae, Pohnpei, Yap], Republic of Palau, Republic of the Marshall Islands). Each of these nations has a distinct language, culture, history, and politico-economic development. (www.doi.gov)

Hawaii is our nation's only island state and truly is rural in nature. The Islands are located 2,500 miles southwest of California and are one of the most remote land masses in the world. Stereotypical images of Hawaii mislead the public about the state's economic and health status. Of all Hawaiian residents, about 20% live in 90% of the state's land mass; much of which is federally designated as medically underserved. The remaining 80% of the Hawaiian population resides on the island of Oahu, in which Honolulu is located — the state's only urban center. The other seven islands of Hawaii are classified as rural, and people who live there face problems similar to those of people living in remote rural areas on the U.S. mainland. Hawaii, however, must contend with additional challenges related to allocating scarce resources to a number of culturally distinct populations. (Box 5.1)

Box 5.1

Ethnic Makeup in Hawaiian Population *

ETHNICITY/RACE	NUMBER OF PEOPLE	PERCENT
UNMIXED (EXCEPT HAWAIIAN)	688,747	60%
CAUCASIAN	252,320	22%
BLACK	17,433	1.5%
JAPANESE	208,653	18%
CHINESE	41,843	4%
FILIPINO	146,380	12.7%
KOREAN	13,728	1.2%
SAMOAN/TONGAN	8,390	>1.0%
MIXED (EXCEPT HAWAIIAN)	223,595	18%
TOTAL**	**1,248,807**	**100%**

* Adapted from DHHS. June-July, 2000. Closing the Gap. (Theme: Asian and Pacific Islanders). Office of Minority Health. www.omhrc.gov
** Due to rounding, subtotals may not equal 100%.

Hawaii's economic situation has exacerbated the health needs of people who live there, especially Native Hawaiians. While the economy in the U.S. mainland surged, Hawaii's stagnated. During the 1990s, agriculture, tourism, and military support, the three pillars of Hawaii's economy, all were negatively impacted by downturns in the American and Asian economies. Consequently, heightened unemployment and under-

employment reduced coverage for many Hawaiian families in spite of the state's highly touted employer mandate for health insurance coverage. (http://www.omhrc.gov/OMH/Health%20Disparities/index.htm)

While a significant number of residents live in rural Hawaii, most of the state's health care resources are concentrated in Honolulu. As a result, six (out of eight) of the state's primary care health professional shortage areas (HPSAs), all seven of its dental HPSAs, and all of its four mental health HPSAs are located on neighbor islands. Access to adequate care is made more difficult on the neighbor islands because the only means of transportation between islands is a plane. Typically, residents of neighboring islands must travel to Honolulu in search of care. It costs about $100 for round-trip airfare, along with the cost of ground transportation to get to the provider, and oftentimes costs for lodging while in the city. Furthermore, there is no reliable means of public transportation on neighbor islands — even access to local care is difficult for the people who live there. Unfortunately, most policy makers in Washington remain unaware of the challenges rural Hawaiians face in accessing health care. Education is needed to change the stereotypical image of Hawaii as a tropical vacation land, as this (mis)perception diverts attention from the health care needs of Hawaiian people in general and its rural residents in particular.

Socioeconomic status
www.cdc.gov & www.cdc.gov/nchs & www.omhrc.gov

Socioeconomically, the AAPI population is extremely heterogeneous — some would say bimodal in nature. For example, some AAPIs are in the highest income brackets while others live in extreme poverty, especially recent immigrants to the U.S. Of the poorest, many are refugees who endured extreme trauma and hardship related to wars and political upheavals in their native country. A number of them spent time in prisons and "re-education camps" prior to immigrating to America. Often AAPIs are stereotyped as a "model" minority group having few health or social issues. In reality that is not the case, evidenced by the following statistics.

- Of all AAPIs, more than 40% have limited English proficiency and a high proportion are functionally illiterate. (Chapter 1, Chapter 2)

- In respect to high school graduate rates, there is a wide variation among the AAPI subgroups; for example, very few Hmongs (only 31%) complete high school compared to Japanese (88%).

- With respect to advanced education, more than half of South Asians earned at least a bachelor's degree but less than 6 percent of Tongans, Cambodians, Laotians, and Hmongs completed college.

- In 1993, the poverty rate of AAPI families was higher (14%) than that of non-Hispanic whites (8%).

Health status

Complete and adequate data on health status are not available on AAPIs in general and for ethnic subgroups in particular. Furthermore, no data system has been developed to systematically monitor their health status. Emerging data on AAPI subgroups clearly show that there are important disparities in their health status and access to health and social services. (http://www.omhrc.gov/rah/index.htm)

Hawaii in particular enjoys a reputation of having many positive health status indicators, but the state still must contend with a number of serious public health issues. For example, the rates of suicide, hepatitis A and C, measles, mumps, rubella, chronic and binge drinking, cancer, diabetes, and obesity are health status indicators that are worse in Hawaii than the U.S. as a whole. These are other examples of health disparities within the AAPI population.

- More than 2 million AAPIs are uninsured.

- The age-adjusted death rate for Native Hawaiians is significantly higher (901 per 100,000) than that for all AAPIs (350 per 100,000) and the total U.S. population (524 per 100,000). Disparity in age-adjusted death rates among Native Hawaiians becomes even more apparent when data are disaggregated by AAPI subgroups.

- In 1994, within the United States–associated Pacific Island jurisdictions, the infant mortality rate exceeded that of the total population (Guam at 9.5 per 1,000; Federated States of Micronesia at 52 per 1,000).

- Chinese Americans have the highest rate of nasopharyngeal cancer of all groups.

- Liver cancer among Vietnamese Americans is 11.3 times higher than among white Americans.

- Cervical cancer incidence rates among Vietnamese women are nearly five times higher than those of white women.

- Of the 50 states, Hawaii has the worst tuberculosis indicators. The incidence of TB is higher among AAPIs (41.6 per 100,000) than white non-Hispanics (2.8 per 100,000), black non-Hispanics (22.4 per 100,000), Hispanics (16.0 per 1000, 000), and American Indians & Alaska Natives (14.5 per 100,000).

Federal initiatives

To address the concerns of the AAPI population, several federal initiatives have been instituted. In June 1997, the Department of Health and Human Services (DHHS) launched the *AAPI Initiative* to identify and address disparities in the health status and improve access to health, mental health, and human services for AAPI communities. Developing the Action Agenda for *AAPI Initiative* mandated community participation. Consequently, designated AAPI community coordinators assumed an active role in identifying the needs of their communities along with the best way to address those concerns. The action agenda included a plan for carrying out the activities as well as benchmarks for measuring progress within these communities. Goals of this initiative are to: (www.omhrc.gov/OMH/Asian%20Americans/index.htm)

- Improve the quality of life, health, and well-being of AAPIs by increasing their access to and use of health and human services.

- Increase and improve collection, analyses, and dissemination of research and data about AAPI populations and subpopulations.

- Increase the number of programs and projects, including demonstration grants targeted toward AAPIs.

- Increase outreach to and participation of AAPIs in DHHS or DHHS-sponsored training programs.

- Ensure that issues affecting underserved AAPI populations are addressed through increased representation in the DHHS workforce and participation in DHHS operations.

The *Native Hawaiian Health Care Improvement [Reauthorization] Act* extends appropriations for Native Hawaiian Health Programs (2002 to 2011) and supports local communities adhering to a lifestyle based on their cultural traditions. The *Presidential Commission on AAPIs* consists of 15 representatives from the AAPI community who advise the president on actions needed to improve the lives of AAPIs. http://www.senate.gov/~inouye

Patterns of accessing health care

To reiterate, the AAPI population comprises many ethnic subgroups, each holding unique health beliefs and care-seeking experiences. For some ethnic groups, significant disparities exist in their health status and ability to access care. *The Racial and Ethnic Disparities in Access to Health Insurance and Health Care* prepared by the UCLA Center for Health Policy Research and Kaiser Family Foundation reports that fewer AAPI (64%) have job-based health insurance coverage than the white population (73%); and, AAPIs are more likely to be uninsured (21%) than are whites (14%). Compared to the white population, the likelihood of Medicaid or other sources of public and private coverage are similar for AAPIs.

Upon closer scrutiny of specific subpopulations, more than 50% of Southeast Asians living in the U.S. do not have job-based coverage. Hidden within the aggregate data customarily collected on AAPIs are statistics that reveal surprising lags in the health and well-being of people residing in the Pacific basin. Higher infant mortality, lower life spans, higher fertility, very high rates of diabetes and other chronic diseases among middle-age adults are some of the indicators that fall below the national norm. Other disparities are associated with rapid population growth, lower educational levels, depressed incomes, and double-digit unemployment rates. Infant mortality rates in American Samoa, for example, are almost twice as great while its per capita income is 25% less than the U.S. average. In 1994, of all Southeast Asians 50% lived in families where no adults worked outside the home; by 1997, the rate had decreased to 16%. Despite this favorable economic trend, more than half of all Southeast Asians remain in poor or near-poor families.

Regardless of age, AAPIs are less likely than whites to have a regular source for health care and are at greater risk for having certain easily detected, preventable, and chronic diseases (e.g., cervical cancer, pneumonia, and diabetes). Increased prevalence of these chronic conditions correspondingly increases the need for a regular provider and routine physician visits. Lack of health insurance exacerbates these differences, further compromising AAPIs' connection to the health care system. Their health status may be further affected by recent changes in welfare laws. For example, many new AAPI immigrants are not eligible for Temporary Assistance to Needy Families and Medicaid benefits. Others perceive that applying for such benefits may jeopardize their ability to become U.S. citizens. Associated with the wide diversity among AAPIs is the need for health care providers to learn what constitutes culturally and linguistically appropriate health care services for clients from the various ethnic subpopulations.

Recruitment, retention, and education of health professionals

Recruitment, retention, and education of health professionals reflecting various AAPI communities is an ongoing process. Some ethnic groups such as the Chinese, Japanese, and Koreans have a higher representation of individuals within health professions while others have very few in the various disciplines (e.g., Vietnamese, Hmong, Laotian). (HRSA — *U.S. Health Workforce Personnel Fact Book 2000*, www.ask.hrsa.gov) In 1999, the proportion of Asian physicians in nonfederal settings was reported to be almost 10% — significantly higher than any other racial minority group. (www.state-healthfacts.kff.org) There is a maldistribution of providers, and some Asian communities are particularly underserved. More specifically, residents of the U.S.-associated Pacific jurisdictions live on 104 islands covering an area larger than the continental United States. Here, health professionals are in short supply. Hospital care often requires travel by plane or boat, and patients needing specialty services may be referred from as far away as the Philippine or Hawaiian Islands. In American Samoa, for instance, 30% of the total health budget is devoted to off-island referrals, thereby further reducing sparse resources that might be allocated for health-promotion and wellness-prevention programs. (Chapter 1, Chapter 7, Appendix C; Appendix D; Appendix E) For residents of American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam, remoteness from Hawaii and the U.S. mainland creates enormous barriers that transcend geographic distance. Better access to services and trained professionals, though extremely important, are only part of the solution. Transportation issues and geographic isolation make it difficult to attract and retain health professionals, particularly in rural Hawaii. As in other rural states, most Hawaii-based health professionals choose to live and practice in urban areas rather than in rural communities.

The Hawaii State Office of Rural Health has collaborated with the State Primary Care Association, the State Primary Care Office, and Area Health Education Centers (AHEC) to address the needs of health professional shortages. Recruitment and retention programs include the Native Hawaiian Health Scholarship Program (NHHSP) along with the J-1 Visa Waiver Program and National Health Service Corps Initiatives. Telemedicine and telehealth hold promise for enhancing medical care in remote jurisdictions. Telecommunication and computer linkages (digital cameras, video and audio

transmission, the Internet) could connect physicians in Pacific jurisdictions to colleagues in Hawaii and the mainland. Technology also could link health care professionals and paraprofessionals located on outlying islands to a hospital or health department in their own country or territory.

Cultural and linguistical characteristics

Due to space constraints, it is not possible to present an extensive discussion on all of the various ethnic groups that make up the Asian American and Pacific Islander population. The next section highlights general cultural and linguistic characteristics for seven of the predominant ethnic groups, specifically, Cambodian (Khmer), Chinese, Filipino, Hmong, Japanese, Koreans, and Vietnamese. To reiterate, the information included in the next few paragraphs *is not absolute*! Box 5.2 provides examples of general health beliefs held by some AAPIs. It is important not to stereotype individuals! There are wide extremes in the extent of AAPIs acculturation to mainstream American society. However, the information in the next section can serve as a springboard to learning more about the culture and health care beliefs about other AAPI ethnic communities.

Cambodian (Khmer)

Prior to 1970 few Cambodians migrated to the United States. Between 1975 and 1979, more came; some fled civil unrest while others left Thai refugee camps to resettle in the U.S. and Canada. The first wave of Cambodian immigrants for the most part comprised well-educated professionals and people associated with the American government. Between 1980 and 1985, the second wave of immigrants arrived. Generally, they came from rural agrarian regions of Cambodia and included a large number of widows and orphans — survivors of the civil war. Compared to the first immigration wave, individuals in the second wave had little education and did not have the necessary skills to readily adapt to U.S. culture. Since 1985 most Cambodian immigrants (third wave) have been sponsored by relatives in the U.S.

The predominant language spoken by Cambodians are dialects of Khmer; the written form of the language is based on Sanskrit from India. Many Cambodian elders cannot read or write their language, much less the English language. Younger family members who attend school or work in the U.S. usually have a better command of the English language. When communicating with individuals of Cambodian origin, speak slowly and seriously, and do not use idioms in the conversation.

Cambodians have a flexible attitude regarding time — tardiness for appointments is not unusual. Their world view emphasizes the past and remembering deceased ancestors. However, present time is taken into consideration because one's actions *today* influence the future. Cambodians, who are predominantly Buddhists, believe in reincarnation (rebirth). *Samsarsa* refers to continual rebirth and death, and this belief impacts the lifestyle and health behaviors of Cambodian people. Chinese medicine and herbs along with spiritual healers (Krou) are used more by family elders. Refer to the bibliographic

Box 5.2

<div style="border:1px solid">

EXEMPLAR: General Health Beliefs of Some AAPIs

Releasing body toxins

Chinese beliefs are pervasive among Asian populations but ethnic variations also are evident. For example various methods are used to release evil sprits or illness causing toxins from the body. These procedures can cause an ecchymotic area on the body as the illness/toxin passes. Degree of darkness (ecchymosis) may be an indicator of seriousness of the illness. Sometimes the ecchymotic area is punctured to express blood, thereby releasing the illness-causing toxin. Puncturing may occur with an unsterilized sewing needle which was used on others. These are other practices preformed on the skin, over the area of pain.

cupping

Cotton or tissue is burned in a small glass jar/cup. After flame extinguished, cup/jar is placed over area of pain; remaining in this position until air within it has cooled. Vacuum is produced resulting in rounded ecchymotic area on the body.

coining

Using an object with a round edge (i.e., spoon, coin, etc.), skin is lightly stroked until an irregular oval bruise appears (ecchymotic area).

pinching

Skin pinched until a narrow bruise appears; often found between the eyes of a person with a headache.

herbs

A variety of healing herbs often imported from China or other Asian (native) nations, as these may not be available in the U.S.

Yin[g] (cold) and Yan[g] (hot) imbalances

dyspnea

Too much Ying; treat with hot soups/broths and wear warm clothes.

nausea/vomiting

Too much Ying; treat with hot soups/broths and wear warm clothes.

constipation/diarrhea

Too much Yang; treat with fruits, vegetables, and other Ying foods.

fatigue

Too much Ying; treat with hot soups/broths and wear warm clothes; ginseng a common herbal remedy.

*Sources: Geissler, 1994; Lipson, Et al., 1996; Spector; 1996

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resources at the end of this chapter for additional information about Cambodians, their culture, health beliefs, and care-seeking behaviors.

Chinese (Chinese American)

The Chinese people have a long history in the U.S. The first Chinese laborers immigrated to the U.S. from 1840 to1882 to work on the transcontinental railroad. The 1882 Chinese Exclusion Act suspended their immigration. From 1924 to 1965 the National Origins Quota Act allowed 105 Chinese to annually immigrate to the U.S. By 1970 the U.S. Chinese population increased by 84%.

Most Chinese Americans are quite fluent in English, especially longtime U.S. residents. Cantonese and Mandarin are the most common languages spoken by recent immigrants from China. The language that is spoken in the home, however, depends on a person's age, recency of migration, and degree of American acculturation. For example, elderly Chinese (especially women) may be unable to read or write any language, while younger people may be bilingual. Chinese Americans who have been in the United States for several generations may speak only English. Chinese Americans participate in many religions. It is not uncommon for a family to honor deceased ancestors, especially during major holidays such as the Chinese New Year. Burning incense and eating symbolic foods are significant parts of these holidays.

The Chinese language is quite expressive and may appear "loud" to non-Chinese observers. "Loudness" often is carried through to the English language; hence, a person of Chinese origins may unintentionally appear abrupt to one not familiar with the culture. Generally, Chinese people are shy especially in unfamiliar environments; privacy is important and most are extremely modest. Their time orientation tends to be past in nature and being on time may not be valued by traditional Chinese societies. Past time orientation probably does not apply to those who have lived in the U.S. for several generations.

Health behaviors and care-seeking behaviors vary with an individual's age and degree of acculturation into mainstream American society. Sociologists describe three major immigrant groups in respect to acculturation, health beliefs and care seeking behaviors.

* *Early immigrants* arrived in the U.S. 40 to 60 years ago; they are the strongest believers in Chinese folk medicine.

* *Newer (recent) immigrants* arrived in the U.S. within the past 20 years; they combine Chinese medicinal practices with Western medicine.

* *First and second generation Chinese Americans* arrived in the U.S. within the past decade; usually they are well-educated (often professionals) and mostly use Western medicine.

Chinese medicine attributes physical illness to an imbalance of Yin(g) and Yan(g). Many Chinese Americans use cultural remedies for minor ailments such as colds and skin disorders but most seek Western medicine (doctors) for more serious health prob-

lems such as cancer. When sick, the advice of family and friends is first sought (self-care). If these interventions are ineffective, a professional Chinese practitioner is sought and makes a diagnosis based on traditional medicine; then he prescribes herbs, acupuncture and/or some other intervention to treat the client. Herbalists and acupuncturists often are used in conjunction with Western medicine. For additional information about Chinese Americans and their health beliefs, refer to the bibliographic resources at the end of this chapter.

Filipino

Around 1700, the first wave of Filipino Americans arrived in New Orleans, LA, when Manila men deserted Spanish galleons in Mexico. Between 1906 and 1934 male agricultural workers (Manong generation) settled in Hawaii and along the west coast. In 1934 the Tydings-McDuffie Act made the Philippines a commonwealth of the U.S. and restricted the annual immigration quota to 50 Filipinos. Between 1946 and 1965 citizenship was granted to Filipinos who were part of the armed services during WWI (recruits, war brides). In 1965, the Amended Immigration Naturalization Act (circa 1934) relaxed quota restrictions. Subsequently, large numbers of young Filipino professionals, unskilled workers, and families migrated to the U.S. Of these, a significant number were health care professionals. Eighty-five languages are spoken in the Philippine Islands but Philippine is the official national language. English is the language of choice for many and Filipinos speak it with a distinct accent. When communicating with someone from this ethnic background, the speaker should be aware that Filipinos are quite sensitive to tone of voice and one's manner of speech.

Traditional Filipinos abide by both past and present time orientation. "Filipino time" usually implies being tardy in social settings but Filipinos adhere to "business time" for appointments. God-willing (*Bahla na*) is a fatalistic outlook on life that also influences Filipinos' time orientation. In other words, one should accept — without question — what life has in store for that individual. They use both Western and traditional healing practices. Associated with the strong historical Chinese influence on Philippine culture, elders often use herbal medicine prior to seeking Western medicine. Many continue to use traditional practices in conjunction with mainstream healing. Catholicism is the predominant religion and it is important for a priest to be summoned when the patient is very ill. For further information about the Filipino people, refer to the extensive citations listed in the bibliographic resources at the end of the chapter.

Hmong ("human being")

Hmong people are found in Southeast Asia, which includes regions of southern China, Laos, Vietnam, Burma, and Thailand. Hmong are thought to be indigenous people who live in the mountainous areas surrounding the Yellow River of China. Associated with their geographic isolation, Hmong people have retained their unique language and traditional customs. Life in their homeland tends to be rugged with no running water or electricity. Hmongs have a short life expectancy.

Their association with the U.S. has been a rather recent phenomenon. During the Vietnam War they fought for the U.S. Central Intelligence Agency against the Commu-

nists. When the war ended, Hmong people were targeted for genocide by Communists who had taken control over Laos. Large numbers were killed or injured by Communist military aggression and biological and chemical warfare. Civil unrest forced some to migrate to enter the U.S. as political refugees (circa 1975). Originally, most came from Laos; however, many had lived for years in Thai refugee camps. Hmongs continue to migrate to the U.S. Most of the more recent emigrés were sponsored by relatives who arrived here earlier and/or for perceived employment opportunities.

Most elders speak only Hmong. Many men also speak Lao, which they learned while serving in the Laos military or working for the Laos government. There are two Hmong dialects, White and Green (sometimes called Blue). The written form of the language was not developed until the late 1950s. Younger people tend to be bilingual, speaking both English and Hmong. In fact, children of immigrants may possess only basic Hmong language skills; therefore, they are not able to serve as adequate interpreters for their parents or grandparents. (Chapter 1, Chapter 2) Most of the older people have had little, if any, formal education. In many instances they are not literate in their own language much less the English language. Conversely, younger individuals may be literate in English but not able to read or write Hmong. Consequently, intergenerational language barriers are not uncommon within a family. Currently, Hmong communities are making an effort to teach their youth to read, speak, and write the traditional Hmong language.

Hmongs communicate in an indirect manner and make every effort to present a positive image. They are very polite, reticent, and highly sensitive to disrespectful and prejudicial behavior. Prolonged and direct eye contact is considered rude. Generally, they do not protest anything health processionals tell them. With respect to orientation toward time, elder Hmongs usually are present oriented. Calendars and clocks are rarely used in rural Laos; hence, Hmongs who were born there do not know their actual birthdays. While in refugee camps, a birth date often was assigned to an individual. Consequently, some may actually be younger, or older, than the stated age on official documents. Keeping appointments is difficult for some. For example, it is not unusual for a Hmong patient to arrive early in the morning on the day of a medical appointment. This behavior is occurring less often as Hmong children are socialized into Western culture. Social events within the Hmong community may begin several hours after the scheduled time.

Hmong people eat special foods when ill or not feeling well, such as boiled rice soup with small amounts of chicken. They are suspicious of meat purchased in a store, believing that it contain chemicals that are not healthy to eat. The appearance of the chicken (e.g., color of the feet) enters into their beliefs regarding poultry as a healing food. Many prefer to kill the animals they eat. Hmong people traditionally grew and used opium for its analgesic properties; hence, they expect the same kind of relief from Western medicine. Opium is still used by some Hmongs in the United States. Medications are readily accepted but individuals may not follow dosage instructions. Often a higher dosage is ingested in an effort to obtain relief from pain.

The majority of Hmongs practice their traditional religion known as animistic. Traditionalists hold the belief that the body has three souls. When someone dies, one soul goes to heaven, one remains with the body, and another is reincarnated. Some practice ancestor worship, believing ancestral spirits have the ability to protect. In other cases, deceased ancestors are thought to cause harm when not receiving sufficient honor from earth-bound relatives. Traditionalists may prefer a spiritual healer who communicates with the spirit world. During healing rituals, extended family gather in the home. As part of the ceremony, the shaman rides an imaginary horse to the spirit world in an effort to learn why the person is ill and what sacrifice is required to restore health. The healing ceremony often involves sacrificing a chicken, cow, or pig. The purpose is to send the animal's spirit to the nether world in lieu of the ill person's spirit, which is believed to have been stolen or have wandered away. The animal's spirit also is expected to protect the person from further harm. Amulets may be applied during the ceremony; they have protective powers as long as the person wears them.

Females usually care for the sick. Home remedies and traditional medicine practices often are used prior to obtaining care from a Western health care provider, at which time the condition usually is quite advanced. Western health promotion and illness prevention practices are not readily accepted by Hmongs, associated with the widespread belief that Western foods and medical procedures can cause harm. Again, more citations about Hmongs can be found in the bibliographic resources at the end of this chapter

Japanese

The Japanese have a long history in the United States, first immigrating here around 1885, settling along the West Coast and in Hawaii; immigration peaked from 1900 to 1910. During World War II (circa 1942) persons of Japanese ancestry living in California, Washington state, and Oregon were forcibly moved to relocation camps. Since 1950, significant numbers of individuals departed from Japan for the United States. Recent immigrants tend to be well educated, primarily settling in metropolitan areas having a significant Japanese community. Their extended immigration history has created a unique layering of generations that is integral to Japanese American culture. Individuals often identify themselves by the generation in which they were born. National identity declines with each successive generation; however, that should not be equated with a lack of strong ethnic identity among Japanese Americans. *Issei* are first-generation Japanese Americans, having a strong sense of national identity. *Nisei* are second-generation Japanese Americans, born and educated in the United States. Even though they may seem to be acculturated, their feelings and attitudes are rooted in Japanese culture. *Sansei* (third-generation) and *Ynsei* (fourth-generation) Japanese Americans are highly acculturated. Their beliefs and behaviors are typical of other American-born counterparts and are less connected to the traditional Japanese culture than are Issei, Nisei, Sansei, and Ynsei. The language used by Japanese Americans varies by how long they have resided in the United States. For example, Japanese is the major language used by Issei. Nisei usually are bilingual. Later generations may speak only English. Most recent immigrants are able to understand and speak English.

With respect to Japanese interaction with the American health care system, older Japanese Americans generally do not ask questions about their care or treatment plans. Illnesses such as cancer are not freely discussed outside of the family. Self-restraint, polite refusal/hesitation, self-control, and the ability to endure (stoicism) are valued in the Japanese culture. Facial expressions tend to be measured and well-controlled, with little direct eye contact occurring during conversations. Typically, older people of Japanese extraction nod their heads when a health professional is conversing with them. However, this nonverbal response may not be indicative of understanding or agreement; rather, it is a cultural sign of respect for a highly regarded person. (Chapter 2)

As for time orientation, promptness is important and Japanese Americans often are early for appointments. Most follow a Westernized lifestyle and health-related practices. Older individuals, however, may not respond to an illness until the condition is quite advanced. This practice may contribute to certain health disparities within the group. Younger people acknowledge illness more readily and practice self care management along with Western medicine. Japanese Americans are diverse in their religious affiliations. The degree to which Japanese use traditional and spiritual healers depends on the length of time they have been in the United States and their religion. Refer to the bibliographic resources at the end of this chapter for more information about Japanese Americans.

Korean

Koreans started arriving in the United States and Hawaii as early as 1903. Between 1903 and 1920 about 8,000 left Korea for U.S. shores. Some were attracted by American Christian missionaries. Some left for political reasons since the Japanese controlled Korea, others arrived because of the famine, and a few came to work on plantations. Men brought their families with them out of fear that they might not be able to return to Korea while Japan was in control of their country. From 1950 to 1965 about 17,000 Koreans entered the U.S. The War Brides Act (1947) allowed Asian wives and children of servicemen to enter on non-quota status. The first wave of Korean immigrants (before 1965) were few in number and settled across the nation, most of whom were working-class citizens and farmers. The Immigration Act of 1965 brought the second wave of immigrants, most leaving for economic reasons. Many were middle-class, college-educated people, including physicians, nurses, pharmacists, and dentists.

Their predominant language is Korean; however, English may be preferred by individuals who have been in the U.S. for an extended time. Older individuals may or may not speak English. The English-speaking skills for some may be limited to a few phrases, but most understand more than they are able to speak. In other words, an individual's ability to speak English does not imply his or her ability to read or write the language. Older Koreans may learn to speak English from other family members (often grandchildren), radio, and television. Koreans who have been in the U.S. for several generations may not be familiar with the native language and are fully literate in English.

Korean Americans consider time and punctuality to be important. "Present time" is about living and sustaining peaceful family relationships. Past orientation is integral to family identity and through the past, life's lessons can be learned. They are predomi-

nantly Christian but Taoism, Buddhism, and Confucianism beliefs permeate Korean culture. It is not unusual to have a mixture of faiths in one household. Chanting and praying are common practices among people of all religions. Many view illness as a result of bad luck or misfortune or the outcome of having committed a wrongful or hurtful (*karma*) act in the past. Stoicism, helplessness, denial, and depression are common responses to the belief that one cannot change the course of fate.

Traditional herbal healers (*hanui*) are used in some cases but herbal therapies (*hanyak*) are used widely. Traditional healing practices usually focus on restoring balance to the body and/or soul and/or its harmony with nature. Cities with large Korean populations have herbal shops where traditional healing products can be purchased. The *hanui* may use acupuncture and other traditional remedies that may leave marks on the skin (e.g., ecchymosis associated with cupping). Eastern and Western medicine are used by many Korean Americans and some may use both simultaneously. The degree to which traditional (spiritual) healers are called upon depends on the length of time a person has lived in the United States and his or her religion. Refer to citations in the bibliographic resources at the end of this chapter for more information about Korean culture and health practices.

Vietnamese

Prior to the Vietnam War and these people's subsequent arrival on U.S. shores (circa 1975), Americans knew little about Vietnamese people. From 1975 to 1977 many Vietnamese people fled their country via the South China Sea and came to the United States. Most in the first wave of immigrants consisted of intact families; many had wealth, were well-educated professionals, and/or had connections with the U.S. government. Once here, they readily became acculturated and financially self-sufficient. Between 1980 and 1985, a second wave of immigrants arrived. Of these, some were men who had enlisted in South Vietnam's armed forces; others were fishermen and traders. Many in the group had spent time in refugee camps. Most departed from their homeland quickly, to seek refuge and political freedom, often in extremely overloaded boats ("boat people"). Compared to the first wave of more affluent immigrants, later arrivals have not adapted as readily to U.S. societal expectations.

Three major languages are spoken by Vietnamese people: Vietnamese (Bac, Nam, and Hue dialects), French, and Chinese. Some Vietnamese are bilingual or trilingual but some speak only one language. Associated with American involvement in Vietnamese politics (1960-1970) some natives adopted English as their second language, albeit with a distinct accent. A strong Chinese influence is evident in the Vietnamese culture. For example, respect is shown by avoiding eye contact with a person perceived to be of a higher status (age, gender, education). Likewise, nurses and doctors are highly esteemed. Vietnamese people show respect by slightly bowing their head and by using both hands in giving something to another person. Personal space among Vietnamese people is more distinct than among Anglo Americans.

Two religions predominate — Catholicism and Buddhism. When ill, Catholics adhere to traditional Catholic rituals, such as reciting the rosary, reading prayers from a

prayer book, and participating in a novena; they may request daily visits from a priest. Theravada Buddhists believe individuals must seek their own salvation and are reincarnated in another life. They strive for the ultimate experience of Nirvana and pray silently among themselves. Buddhists practice acts of generosity (*Dana*), to be reciprocated some time in the future (*Karma*). Among Vietnamese, illness is attributed to several causes. Some believe it is related to natural causes having immediate consequences, such as with the ingestion of spoiled food. Another explanation for illness is steeped in traditional Chinese philosophy — the balance of *ying* and *yang*. Yet another explanation is supernatural forces, for example, disability being a punishment for a sin ([fault] committed in another life) or the violation of a religious taboo (committed in this life). Mental illnesses sometimes is attributed to the disruption of harmony between body and spirit, or ancestral spirts haunting a living relative because of past bad behavior. Better-educated and more affluent Vietnamese are more likely to adhere to Western medicine, germ theory, and physical aberrations. When sick, most will try home remedies, consult with spiritual advisors or take Chinese herbs before seeking out Western medicine. They may not acknowledge their health problem until it has reached an advanced state, which may be a factor in their reported health disparities. Along with stoicism, the person may not voluntarily request pain medication for fear of becoming addicted or having undesirable side effects. Some believe traditional healers can exorcise evil spirits but their treatment ritual must fit the pattern of symptoms.

Vietnamese have a past orientation regarding time but this varies with the degree of acculturation of the individual into mainstream society. Frequently it is fashionable to be late to social functions but most who have been in the U.S. for a while understand the importance of keeping appointments. Health care professionals should provide Vietnamese patients with a telephone number in case their appointment must be canceled or when late. Vietnamese usually are compliant with expectations of health professionals; therefore, emphasize the importance of adhering to medication regimens and scheduled appointments. As with other AAPI ethnic groups, the degree to which Vietnamese use traditional healing practices will vary depending on the length of time they have been in the U.S. and their religion. Refer to the bibliographic resources for additional information about Vietnamese culture and healing practices.

SUMMARY

This chapter focused on AAPIs, the third largest racial minority in the U.S. Demographic trends, socioeconomic issues, health status, and patterns of accessing health care within the AAPI community were examined. Characteristics for seven of the larger groups were highlighted: Cambodian (Khmer), Chinese, Filipino, Hmong, Japanese, Koreans, and Vietnamese. Information in this chapter, along with Chapter 2 and Chapter 7, offers core content to learn more about AAPI ethnic groups.

Chapter Five

Discussion Questions

- Review census data for your state and community. Describe AAPI immigration trends and patterns. Elaborate on specific AAPI ethnic groups — where they live, work, and attend school. What has been the impact for state/local health and human services? If possible, provide anecdotal information related to state AAPI immigration patterns.

- Describe demographic trends and patterns of AAPIs in relation to the population as a whole and with other minority groups in particular. Compare and contrast trends among AAPI rural residents with counterparts in urban areas.

- Identify policies and programs that exist or are needed in your catchment area to address the needs of AAPIs. Suggest ways that these programs/services can be designed to meet the cultural and linguistical preferences of these clients.

- Describe health disparities that exist within the AAPIs in your state.

- Using the information in this chapter along with Chapter 2, interview at least two AAPIs to learn more about their culture, health beliefs, and expectations of health care providers. How are the responses similar or different? Based on that information how can services in your facility be modified to be more culturally and linguistically appropriate for clients of various AAPI ethnic groups?

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942 Market St., Suite 200
San Francisco, CA 94102
(415) 954-9988
http://www.apiahf.org

Asian and Pacific Islander — Health Organizations and Programs
http://www.apiahf.org/links/links5.html#apihealth

Association of Asian Pacific Community Health Organizations
1440 Broadway, Suite 510
Oakland, CA 94612
(510) 272- 9536
http://www.aapcho.org

Asian Pacific Resource Center
Montebello Library
1550 W. Beverly Boulevard
Montebello, CA 90640
(323) 722-2650
http://www.aphcv.org

Center for Asians and Pacific Islanders
3702 East Lake St., Suite 200
Minneapolis, MN 55406
(612) 721-0122
http://www.capiusa.org

Ethnic Health Resource List
Utah Department of Health
List of educational materials in various languages, where and how to obtain the materials
http://www.health.state.ut.us/hrm/ethnic/language.html

Hawaii State Department of Health
P.O. Box 3378
Honolulu, HI 96801-3378
(808) 586-4400
http://www.state.hi.us

Hawaii Rural Health Association
3040 Umi St.
Lihue, HI 96766
(808) 241-3427
E-mail: mjsweene@mail.health.state.hi.us

National Asian Pacific American Families — Against Substance Abuse
340 E. Second St.; Suite 409
Los Angeles, CA 90012
(213) 625-5795
http://www.napafasa.org

Philippine Nurses Association
http://www.pna-america.org

National Asian Pacific Center on Aging
Melbourne Tower
1511 Third Ave., Suite 914
Seattle, WA 98101
(206) 624-1221
http://www.napca.org

Office of Hawaiian Affairs
711 Kapi'olani Blvd., Suite 500
Honolulu, HI 96813
(808) 594-1888
Native Hawaiian statistics on population, housing, land, health, crime, education, income, etc.
http://www.oha.org

UCLA — Center for Pacific Rim Studies
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CHAPTER SIX
OBJECTIVES

After reading this chapter you should be able to:

- Describe demographic trends within the Hispanic/Latino population.

- Delineate the ethnic makeup of the Hispanic/Latino population.

- Discuss sociocultural and economic factors impacting the health status of the Hispanic/Latino population.

- Compare and contrast the health status of various ethnic groups within the Hispanic/Latino population.

- Compare cultural preferences and health beliefs of the predominant Hispanic/Latino population, specifically Mexican Americans, Puerto Ricans, and Cubans.

- Highlight health disparities among Hispanic/Latino ethnic subpopulations.

- Develop awareness of health-related issues experienced by Hispanic/Latino seasonal and migrant farmworkers.

- Compile a bibliographic resource list related to Hispanics/Latinos and their cultural beliefs and health status.

HISPANICS / LATINOS

OVERVIEW

This chapter provides information about Hispanics/Latinos, an ethnically, culturally, and linguistically diverse population. The second-largest minority group, they are the fastest-growing minority group. To be reviewed herein are demographic trends, socioeconomic issues, health status, and patterns of accessing health care within the Hispanic/Latino community. General cultural and linguistic characteristics for the three largest ethnic groups will be examined in some detail, specifically Mexican Americans, Puerto Ricans, and Cubans. The content herein can serve as a starting place for health professionals to learn more about the beliefs and values of clients who have Hispanic/Latino origins.

Demographic trends

www.census.gov

The title "Hispanic" often is used in reference to all ethnic groups having ancestral ties to Spain, in reference to the common language shared by those nations. This title obscures ethnic and cultural identities that characterize a very diverse population; hence, the title "Latino" has come into use. Reference to national origin, such as Mexican American, Puerto Rican, Panamanian, Colombian, South American, or Cuban, provides a cultural and ethnic context to the broad category of "Hispanic/Latino." While classification by national origin is useful, it does not acknowledge an individual's degree of acculturation into mainstream society. For instance, fifth-generation Mexican Americans stereotypically are classified with recent immigrants from Mexico. It cannot be overstated — there are distinct cultural differences between U.S.-born and foreign-born individuals having the same ethnic ancestry. Nonetheless, those having Hispanic/Latino origins share some traits; for example, the Spanish language (despite the range of national dialects) and historical elements associated with Spanish colonization that influenced healing and religious practices.

Census 2000 indicates Hispanics number about 33.1 million and nearly match the black population in size (34. 7 million). Compared to other groups, Hispanics grew at a

record pace from 1990 (9% of the total population) to 2000 (about 12.5%). (Chapter 1) Hispanics/Latinos are ethnically diverse, and there is considerable variation in the population's distribution by nativity and citizenship. Of all foreign-born U.S. residents, a larger proportion of foreign-born Hispanics/Latinos are not naturalized citizens (81.7%) than other foreign-born non-whites (49.4%). Sometimes the large classification of Hispanic/Latino is subcategorized by race and/or ethnicity. The Hispanic/Latino population is made up mostly of people with Mexican origins (63.4%), followed by Central or South American origins (14.3%), Puerto Rican (11.0%), other Hispanic origins (7.3%), and Cuban (4.0%). (Figure 6.1) About two-thirds of all U.S. Hispanics/Latinos are of Mexican origin. Puerto Ricans and Cubans are the other two largest Hispanic/Latino subgroups. Of the three, Puerto Ricans are reported to have the poorest health status; Cubans are the healthiest. Mexican Americans fall somewhere in between. With the exception of Cubans, a large number Hispanics/Latinos of all ethnic origins live in rural areas across the United States. Figure 6.2 displays the distribution of the nonmetropolitan Hispanic population in the U.S.

Comparing non-Hispanic whites, Hispanics/Latinos are younger and have a higher proportion of children under 15 years of age (31.1%) versus non-Hispanics (20.1%). In contrast, a lower proportion of Hispanics/Latinos were 55 years old and over (10.4%) compared with non-Hispanic whites (22.9%). The median age of the Hispanic/Latino population (25.6 years) is lower than non-Hispanic whites (36.5 years). Of all the Hispanic/Latino subgroups, Cubans have the highest median age (38.9 years) followed by Mexicans (24.1 years), Puerto Ricans (25.7 years), Central and South Americans (28.1 years), and other Hispanic/Latino subpopulations (28.5 years).

Despite significant progress, the Census Bureau reported in 1996 the educational attainment of Hispanics/Latinos was below the rest of the population even with notable improvements. The proportion of Hispanics/Latinos 25 years old and over having less than a 5th-grade education decreased from 1990 (12.3%) to 1996 (10.3%). Still, the proportion of Hispanics/Latinos with low educational attainment (less than a 5th-grade education) is 17 times greater than that of non-Hispanic whites (0.6%). Among young adults 25 to 34 years old, Hispanics/Latinos are less likely to be high school graduates (61%) than are non-Hispanic whites (92%). Fewer Hispanics/Latinos had a bachelor's degree (8.5%) than did non-Hispanic whites (23.8%). Differences in educational attainment levels also exist among Hispanic/Latino subgroups. For example, in 1996, Mexicans 25 to 34 years old were the least likely to have a high school diploma or higher level of education (56.2%).

Socioeconomic status
www.census.gov

Hispanic/Latino people lag the overall U.S. population in material wealth and earn less than non-Hispanic whites. In 1995, among year-round, full-time workers, median earnings of Hispanic/Latino males ($20,553) were 57.7% of median earning of non-Hispanic white males ($35,605). Median earnings of Hispanic/Latino females ($17,855) were

Figure 6.1

DISTRIBUTION OF NONMETROPOLITAN HISPANIC POPULATION, 1990
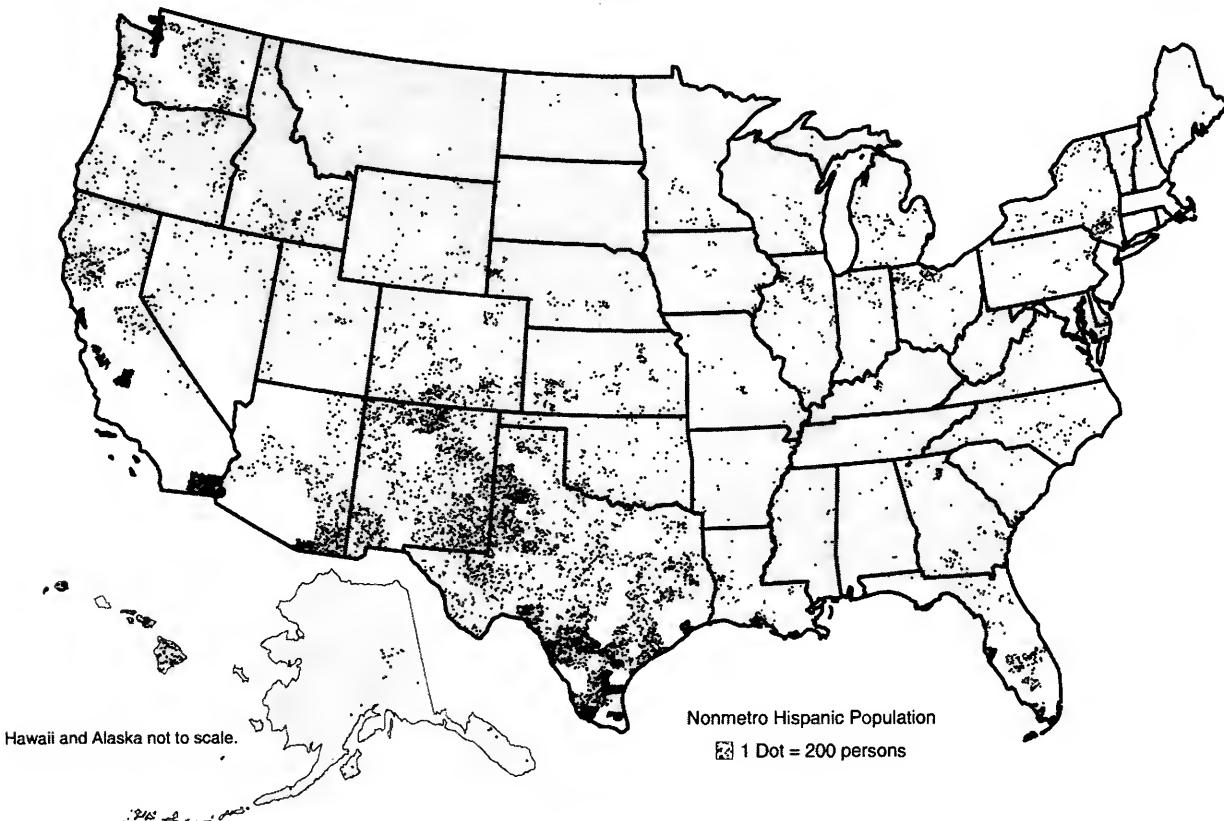
Hawaii and Alaska not to scale.

Nonmetro Hispanic Population
1 Dot = 200 persons

Note: Metropolitan counties are aggregated into white areas on the map.

Source: US Bureau of Census, 1990; revised June 9, 1998.

Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS.

only 71.4% of median earnings of non-Hispanic white females ($25,005). The ratio of female-to-male earnings for Hispanics/Latinos (87%) was higher than female-to-male earnings for non-Hispanic whites (70%). Anecdotal reports indicate the disparity of female-to-male earnings often becomes a source of contention among some Hispanic/Latino couples stemming from more traditional gender role expectations. Differences for year-round, full-time workers also is evident in the distribution of the earnings. At the low end of the earnings distribution, Hispanic/Latino males (about 10%) earned less than $10,000 a year compared to non-Hispanic white males (3.6%) in this income category. At the high end of the income distribution, fewer Hispanic/Latino males (7.5%) had earnings of $50,000 or more compared with non-Hispanic whites males (26.5%) in the same income category. Among females, more Hispanics/Latinos (15.6%) had earnings of less than $10,000 compared to non-Hispanic whites (7.1%) in the same income category. On the higher end of the spectrum, fewer Hispanic/Latino women (26.6%) had earnings of $25,000 or more compared to non-Hispanic white women (46.7%) in the same income category.

Hispanics/Latinos are more likely than non-Hispanic whites to live in large households. In 1996, the average size of Hispanic/Latino households was larger (3.53 people) than non-Hispanic white households (2.48 people). Five or more people represented a significantly higher proportion of Hispanic/Latino households (23.3%) than in non-Hispanic white households (8.3%). Considering annual income and household size, Hispanics/Latinos are more likely to live below the poverty level than non-Hispanic whites. About one in every 10 people in the U.S. was Hispanic/Latino, yet more than two in every 10 (23.5%) live in poverty. Hispanic/Latino children represent 14.5% of all U.S. children but make up 27.8% of those living in poverty. More Hispanic/Latino children under 18 (47.6%) lived in poverty than did non-Hispanic white children (31.4%).

Health status
www.cdc.gov & www.nchs/fastats/hisfacts.htm & www.cdc.gov/nchs & www.omhrc.gov

Even though the majority are citizens or legal residents, disparities exist in the health status of Hispanic/Latino in various subgroups within the population (Chapter 1). The *Kaiser Commonwealth Fund 1997, National Survey of Health Insurance Report* indicates that even though Hispanics/Latinos compose more than 12% of the total population, they make up nearly one-quarter of the uninsured people. Nearly four in 10 Hispanics/Latinos are uninsured, having the highest uninsured rate of all minority groups. Nationally, 37% of non-elderly Hispanics/Latinos are uninsured, a rate more than double that of whites. Partly, the high uninsured rate is related to not having employer-based coverage. Fewer Hispanics/Latinos (43%) are covered through their workplace compared to non-Hispanic whites (73%). Medicaid (and other public coverage) reaches an additional 18% and covers more than four in 10 poor Hispanics/Latinos. For legal immigrants, welfare reform has decreased the number covered by Medicaid. Legal (documented) residents entering the U.S. after 1996 generally are not eligible for Medicaid. Of those who qualify, some are reluctant to apply out of fear that doing so will jeopardize future citizenship or that they must first repay Medicaid costs before becoming citizens. Undocumented residents do not qualify for Medicaid, except for emergency care.

More Hispanics/Latinos (30%) than non-Hispanic whites (13%) work for an employer who does not offer insurance to workers. The majority of uninsured Hispanics/Latinos work in the agricultural industry (87%); many cannot speak English and do not have reliable transportation. Despite relatively high levels of employment, more Hispanics/Latinos (nearly 60%) live in families with incomes below 200% of the poverty level than do non-Hispanic whites (23%) at this level of poverty. Low-wage workers are less likely to be offered health benefits; furthermore, they cannot afford the employee's share of premiums when insurance benefits are offered. Disparities in job-based coverage are greatest where the primary family wage earner works in a firm with fewer than 25 employees. Of all Hispanics/Latinos, Mexican and Central and South Americans are the least likely to have job-based coverage and the most likely to be uninsured. Puerto Ricans' rates of job-based coverage are equally low, but Medicaid reaches more of them

because they are U.S. citizens by birth. Cubans have higher rates of private insurance (54% through jobs; 11% purchased separately) and are less likely to have Medicaid; about 21% are uninsured.

Patterns of accessing health care
http://www.healthpolicy.ucla.edu/publications

As mentioned in the previous paragraphs, Hispanics/Latinos often have restricted access to health care for a variety of reasons: lack of insurance, unreliable transportation, cultural and language barriers. Of all ethnic groups they are least likely to have a usual provider of care. Uninsured Hispanic/Latino children are twice as likely (32%) as non-Hispanic white children (16%) to lack a usual source of care. Among uninsured Hispanic/Latino adults in fair to poor health, 24% of women and 40% of men have not visited a doctor in the past year. Health insurance decreases but does not eliminate Hispanic/Latino differences in access to physician care. Privately insured Hispanic/Latino men in fair or poor health are less likely (19%) to have seen a doctor in the past year than are non-Hispanic white men (12%). Differences in physician care among women and children persist even among those with comparable health coverage. Without health coverage, Hispanics/Latinos access to health care will continue to lag that of other Americans. In many instances, migrant and seasonal farm workers are eligible to use the services of federally qualified migrant health centers. Additional information regarding migrant health centers can be obtained from the Bureau of Primary Health Care, Migrant Health Program (www.bphc.hrsa.dhhs.gov/migrant/default.htm) and the Migrant Clinicians Network. (www.migrantclinician.org)

Recruitment, retention, and education of health professionals

It is difficult to find detailed data on the Hispanic/Latino health-profession workforce. Partly, this may be attributable to workforce reports presenting data by race and in some cases geographical distribution. (*HRSA — U.S. Health Workforce Personnel Fact Book 2000*, www.ask.hrsa.gov) In 1999, the proportion of Hispanic (all races) physicians in nonfederal settings was reported to be 3.1%. This figure, however, probably does not reflect physicians who practice in Migrant Health Centers, a federal entity. (www.statehealthfacts.kff.org) One can confidently say that Hispanics/Latinos of various ethnic origins are significantly underrepresented in the health professions. Considering their rapidly increasing numbers, there must be coordinated and concerted efforts to recruit and retain individuals of various Hispanic/Latino ethnic origins to the health professions. (Chapter 1, Chapter 7, Appendix B)

Cultural and linguistical characteristics

The Hispanic/Latino population is diverse ethnically, culturally, linguistically, and racially. Due to space constraints, this text cannot discuss all of the ethnic groups that make up the U.S. Hispanic/Latino population. It is important to note that length of time an individual or family has lived in the U.S. and degree of acculturation are significant factors in a person's health status and care-seeking behaviors. The next section highlights general cultural characteristics of Hispanics/Latinos; to reiterate, this *is not absolute!* Rather, the information provides baseline information to learn more about the health beliefs and care seeking behaviors of various ethnic Hispanic/Latino clients. Box 6.1. lists health-related Spanish terms and their definitions.

Ethnic identity

Hispanics/Latinos come from Mexico, Puerto Rico, Honduras, Cuba, and other countries in Central and South America. Point of origian reflects the manner in which they identify themselves as a community, as well as their cultural belief systems, organizational structures, and health beliefs. A Venezuelan native expressed the importance of understanding Hispanic/Latino diversity in these words.

> "If you speak Spanish, [health care providers] think you are Mexican. When we go to a hospital emergency department and the nurses and doctors realize we are Hispanic, they try to get rid of us because they think we need a translator. Or that we are undocumented … which complicates their work. They don't understand about our folk medicine and seem so afraid … think we are doing witchcraft on them. They believe our 'curanderia' (white magic) cures illnesses with leaves and herbs is a bad thing. They need to learn and open their minds to other cultures."

Social organization

Consistent with Americans in general, there is a wide range of family structures in the Hispanic/Latino community. Someone may be considered part of a Hispanic/Latino family without being a blood or legal relative, which can confuse health care professionals of another culture. Assigned roles for individuals vary with family and community value systems. In general, family (*familismo*) is very important to Hispanics/Latinos. For example, it is not unusual for nuclear, as well as extended family members, to accompany a sick person to appointments and be actively involved in decision-making regarding this individual's health care. As part of their care-seeking behavior, Hispanics/Latinos find it essential to make a personal connection (*personalismo*) with a caregiver. For example, during an appointment, the patient may ask the provider seemingly personal questions to familiarize himself or herself with the individual. The client may pick up photographs on the physician's desk, then pass them to other family members for viewing. In general, Hispanics/Latinos feel the individual, rather than the organization, makes the difference. Provision of culturally and linguistically appropriate care means being sensitive to such communication rituals, and organizations should have someone who understands and can respond to those preferences.

Box 6.1

	Universal Spanish Health-related Terms and Definitions
macho/machismo	cultural trait assigned to males emphasizing bravery, honor and integrity; stereotypically viewed as "virile maleness," which connotes brutish and controlling attitude toward women
la surfida	passive participant role sometimes assigned to women especially during pregnancy and labor
familialism	strong attachment to extended and nuclear family
antojos	strong cravings, usually associated with pregnancy that if not fulfilled can lead to abnormalities in the new born
abuelo/abuela	grandparents (grandfather/grandmother)
caida de mollara	fallen fontanelle
compares/compadres	godparents (godfather/godmother)
corto de aire/asfixiado	shortness of breath
diarrhea	diarrhea
distino	fate
dolor	pain
empacho	bolus of food that sticks to the stomach wall causing abdominal pain, vomiting, constipation, loss of appetite, and bloating
fatigo	fatigue
estrenimientol	constipation
las manos de Dios	God's will and/or chance
mal ojo	evil eye, which can result from excessive admiration (jealousy). Children and women are more susceptible; thus best for them to avoid eye contact
mandas	religious promise or pledge
nervioso/ ataque de nervios	nerves/nervous attack
respeto	used to ensure smooth interpersonal relationships by demonstrating respect to the person
sufferimientos	suffering
susto	results from a traumatic emotional experience, freight, shock causing general malaise, irritability, depression, and wasting
mal puesto	illness or hex imposed by another person
simpatico	to be likeable, warm, and have good rapport with others

Sources: Geisler, 1994; Lipson et al., 1996; Spector, 2000

Communication patterns and preferences

Even though all speak Spanish, communication styles differ among the various Hispanic/Latino ethnic groups. Respect is crucial; hence, most do not communicate on a first-name basis with authority figures. Elders, clergy, and authority are given exceptional respect (*respeto*) and subordinates are not to look into the eyes of those individuals. Out of deference for elders, the title *senor* or *senora* is used along with the person's last name. Rarely does one disagree with elders or people of authority (*simpatico*). Handshaking is taught as a sign of respect. In public, the male is the dominating figure (*machismo*); however, at home he is quite open to the opinions of women in the family (*marianismo*). Ultimately, behind closed doors the male and female are reported to make decisions together. Gender role differentiation may be less pronounced in families who have lived in the U.S. for several generations and become part of mainstream society. Compared to most Anglo-Americans, Hispanics/Latinos prefer less personal space and remain physically closer to one another in day-to-day social interactions. When speaking, they are apt to use hand gestures, along with pictures and facial expressions. Establishing a trusting relationship (*confianza*) with another person takes time and is important to Hispanics/Latinos. Failure to recognize this preference may lead to the client not trusting the caregiver and, thus, not reporting such important information as the use of traditional medicinal or pharmaceutical products that were purchased in their native country. Consequently, ensuring continuity of providers becomes an important consideration when designing services for Hispanics/Latinos.

Time concept

Along with ethnicity and race, the time orientation of Hispanics/Latinos differs. Fulfilling family responsibilities and working are life priorities for most. Depending on the degree of Native American influence within the family, Mexican Americans have a more flexible view, with a tendency to focus on the present and be less concerned about the future. Eagerness is not seen as an appropriate behavior, and the concept of *manana* may not actually refer to tomorrow. Cubans, on the other hand, are more future oriented and highly competitive. Since Hispanics/Latinos tend to be a younger population as a whole, obtaining preventive care and keeping a doctor appointments may be lower priorities for them. Consequently, behaviors associated with time perception could be a factor in some of the disparities that exist within a particular Hispanic/Latino subgroup.

Health beliefs and practices

There are wide variations among Hispanics/Latinos in their definition of health versus illness and their care-seeking behaviors. This population has rich traditions of healing. For example, Meso-American Indians had a very sophisticated healing system and established medical schools in Mexico at least 50 years before Jamestown was settled. Their pharmacopeia included more than 5,000 well-studied and efficacious naturally occurring medicinals that were categorized in the Badiano Codix (circa 1552). Their system of healing had strong connections between religion and health. From the ancient Greeks, they inherit the theory that disease occurs when there is an imbalance of the four

Box 6.2

EXEMPLAR: Traditional Medicinals Used by Some Hispanics/Latinos*

Spanish Name	English Name	Use
Ajo	Garlic	Hypertension, antibiotic, cough syrup, tripa ida
Azarcón/Greta	Lead/mercury oxides	Empacho, teething
Damiana	Damiana	Aphrodisiac, frio en la matriz, chicken pox
Estafiate	Wormwood	Worms, colic, diarrhea, cramps, bilis, empacho (purgative)
Eucalipto	Eucalyptus (VicksVapoRub)	Coryza, asthma, bronchitis, tuberculosis
Gobernadora	Chaparral	Arthritis (poultice); tea for cancer, venereal disease, tuberculosis, cramps
Pasmo	analgesic	Used as a poultice (external); as a tea (internal)
Gordolobo	Mullein	Cough suppressant, asthma, coryza, tuberculosis
Manzanilla	Chamomile	Nausea, flatus, colic, anxiety; eyewash
Orégano	Oregano	Coryza, expectorant, menstrual difficulties, worms
Pasionara	Passion Flower	Anxiety, hypertension, sedative
Rodigiosa	Bricklebush	Adult onset diabetes, gallbladder disease
Ruda	Rue	Antispasmodic, abortifacient, empacho, insect repellent (internal & external)
Saliva	Sage	Prevent hair loss, coryza, diabetes
Tilia	Linden Flowers	Sedative, hypertension, diaphoretic
Tronadora	Trumpet Flowers	Adult onset diabetes, gastric symptoms, chicken pox
Yerba buena	Peppermint	Dyspepsia, flatus colic, susto
Zábila	Aloe Vera	External — cuts, burns; internal — purgative, immune stimulant
Zapote blanco	Sapodilla	Insomnia, hypertension, malaria

* *Migrant Clinicians Network www.migrantclinician.org*

humors. The Cuban and Puerto Rican cultures have a strong African influence along with the Spanish and in some cases Meso-American Indians. Some Spanish-speaking Filipinos may have an Asian influence in their health beliefs along with Spanish. Remnants of these ethnic influences still exist among modern-day Hispanics/Latinos. Consequently, health professionals should not assume that because a patient is speaks Spanish, he or she believes in or engages in certain healing practices.

One of the more common beliefs about the cause of disease is related to a disruption between hot and cold principles in the body — illness prevention and health maintenance involves avoiding exposure to extreme temperatures. More specifically, vasoconstriction and a low metabolic rate signify that one has a "cold" disease, and "hot" conditions are characterized by vasodilation and a high metabolic rate. Examples of "hot" diseases (states) include pregnancy, hypertension, diabetes, acid indigestion, susto, ojo, and bilis. Examples of "cold" states include menstrual cramps, frio de la matriz, coryza, pneumonia, empacho, and colic. The goal of treatment for such disorders is to restore harmony and balance in the person's body; thus, "hot" diseases are treated with "cold" remedies, and "cold" diseases are treated with "hot" remedies.

When Hispanics/Latinos become ill, many prefer traditional healing and use a hierarchy of lay healers. First and foremost, certain relatives and neighbors can provide valuable information about health-related problems. An individual whose conditions cannot be treated by a senora or abuela usually is referred to a *yerbero* (herbalist), a *sobador* (massage therapist), or a *partera* (midwife, who also treats problems with young children). If these lay specialists cannot handle the problem, the patient is referred to a *curendaro/curendara*, who may use multiple treatment modalities. This healer is highly respected and may be from a family with a tradition of *curanderisimo* while others may have received the gift of healing (*el dón*) later in life. Generally, there is no direct remuneration for services rendered, but most lay healers accept gifts from the client's family. The curendaro(a) has clear expertise in folk illnesses, but a large proportion of (80%) of his or her clients have medical problems. Most are aware of what they are not able to treat and generally refer people with severe health problems to a health professional. Sometimes a family expects to have both a lay healer and a health professional involved in the treatment plan for their loved one. The challenge for health professionals is to establish good rapport with both the patient and family to learn about healing preferences. Open communication pre-empts integrating the two healing systems into the client's treatment plan. Box 6.2 includes examples of traditional health interventions used by some Hispanic/Latino ethnic groups. Box 6.3 includes two examples of healing practices with ethno-medicinals for hypertension and diabetes; some products can be incompatible with prescribed medications. Ethno-medicinals will vary by geographical region and available plant and animal resources. These products can have powerful psychological and physiological effects; some are toxic. Traditional healing practices are not readily revealed to Anglo-American health professionals. Often the person may not be able to identify the product by name or only know the Spanish word for it.

Obviously, it is not realistic to expect health care providers to know all there is to know about the multitude of Hispanic/Latino ethnic groups. However, it is not too

Box 6. 3

EXEMPLAR: Traditional Healing Practices for Hypertension and Diabetes*

Hypertension is classified as a "hot" illness. Many believe its etiology is due to corajes (anger), susto (fear), and/or "thick blood." "Cool" remedies, such as bananas and lemon juice, are popular as well as teas of passion flowers (pasionara), linden (tilia), or zapote blanco.

Diabetes mellitus is classified as a "hot" illness. While most curanderos encourage consultation with a physician, various remedies may be used to treat the condition including Nopal (cactus), aloe vera juice, or bitter gourd. In some areas of Texas and Mexico, treatment is started with maturique root infusion for approximately one week if the person is extremely hyperglycemic. For maintenance therapy, trumpet flower herb or root infusion (tronadora), brickle bush (prodigiosa) tea, or sage tea (salvia) are used. The proven safety and efficacy of maturique, trumpet flower, or bricklebush preparations are not known. Aloe vera juice is reasonably safe but aloe vera latex is a powerful purgative. (Sage tea taken chronically can lower the seizure threshold and has been reported to cause mental and physical deterioration because it contains thujones and tannins.)

* Migrant Clinicians Network -www.migrantclinician.org

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much to expect familiarity with those in their catchment area. The next section of this chapter discusses the three predominant Hispanic/Latino subgroups in the U.S., specifically Mexican Americans, Puerto Ricans, and Cubans. Most health care providers have one or more of these groups represented in their clientele load.

Mexican American

From a historical perspective, the war between the U.S. and Mexico (1846-1848) resulted in the U.S. gaining nearly half of the Mexican territory. Mexican inhabitants of ceded lands subsequently were offered citizenship along with a promise of property rights. About 80,000 Mexicans ended up living in new U.S. territories, They are the ancestors of fifth-, sixth-, and even seventh-generation U.S. citizens. Many have assimilated into the Anglo population, while others continue to live in cultural enclaves in the southwest. Mexican Americans make up most of the immigrants arriving in the U.S. Between 1900 and 1990, more than 2.5 million Mexicans legally (with appropriate documents) crossed the Mexican-U.S. border. However, significant numbers continue to enter illegally (without documentation), attributable to a large and relatively unsupervised border between the two countries and the need for cheap labor in the United States. Economic and political instability in Mexico further motives Mexican citizens to seek a better life and work across the border. As a group they are diverse in their affinity to the

traditional Mexican culture, based on individuals' educational, social, and economic position as well as their experience with mainstream U.S. culture. Mexican Americans living in urban areas tend to have higher levels of education and are more likely to be bicultural (acculturated into American societal values while selectively maintaining Mexican cultural practices).

The self-ascribed identity of Mexican Americans has changed over time. Around 1980, the title "Hispanic" was used to collectively describe all individuals of Mexican, Cuban, Central America, and Puerto Rican heritage. Later, "Chicano" (specific to Mexican Americans) and "La Raza" were used as expressions of Latin solidarity. While recognizing their Mexican heritage, many prefer to be identified as American because both continents in the western hemisphere are referred to as such. Lack of consensus regarding a title (i.e., ethnic identity) that fits all people of Mexican heritage reinforces the extent of diversity within this Hispanic/Latino subpopulation.

Spanish is the predominant language spoken in Mexico, but many indigenous languages still exist, especially in rural areas. Thus, Spanish continues to be the second language for many Mexican people. The Mexican dialect of Spanish includes the derivative of many Native American words. In day-to-day conversations, most longtime U.S. residents of Mexican heritage speak English — interspersed with traditional Spanish words.

Most but not all are Catholic, and many homes contain small religious shrines. Daily prayer is a common practice. Baptism of babies is mandated especially if the prognosis for survival is poor. The Virgin of Guadalupe, portrayed as the dark-skinned mother of Jesus, is a popular, powerful image and unique to Mexican Americans. The Virgin Mary serves as the cultural model of motherhood, peace, faith, strength, and endurance; many Mexican Americans direct religious promises (*mandas*) and prayers to her. Health care providers can expect to see pictures and statues of the Virgin of Guadalupe along with other religious artifacts near a sick person. Despite the overt religious practices of many Mexican people, attendance at church is sporadic. Religiosity seems to decline with an individual's acculturation into mainstream American society.

Traditional Mexican culture is present oriented — relative to the situation at hand. The perceived flexibility regarding time allows an individual to believe he or she is punctual — even when arriving late for an appointment. Incongruent "time perspectives" often are a source of conflict for Anglo health professionals when caring for more traditional Mexican American clients. Mexican Americans who are bicultural, or assimilated more into mainstream culture, demonstrate increased concern for punctuality.

The Mexican American family structure is patriarchal in nature. *Familialism* dictates that family comes first, including nuclear and extended family members. This cultural value often is the cause of children being absent from school, either to work in the fields to help support the family financially, or to take care of siblings while older relatives work (in the fields). Males are perceived to be healthier than females and children; appearance of healthiness is an important aspect of *machismo*. Women have been portrayed as a passive participant (*la surfida*), especially during pregnancy, but this stereotype probably is not appropriate. Children are highly valued and motherhood is viewed

by many as women's primary role. This cultural value is believed to be a contributing factor to the high teen pregnancy rate among this population. The time surrounding pregnancy and birth (childbearing) is rich with traditional beliefs and practices. Women are designated as the primary family caregivers, and it is extremely stressful for them to be separated from family. Emotionally it is difficult to hand over the care of an ill family member to an outsider. When hospitalized, parents usually stay with the child, who can be traumatized when separated from family.

Grandparents (*abuelo/abuela*) and godparents (*compadres*) have an important role in family decision-making in collaboration with the male head of the household. In the family, mother is responsible for domestic activities and decides when health care is sought for someone who is ill. However, she may not have the authority to give consent for her child's treatment. The male head of household usually is the family spokesperson. In turn, it is prudent that he be consulted regarding treatment options for an ill family member and included in counseling sessions. In the provision of care, it is best if the practitioner is of the same gender as the patient. Women in the family may not provide care in the home if it involves touching male genitalia. Family decisions will supercede recommendations of the health care provider.

Formality and great deference is shown to elders, especially fathers and grandfathers. Elders are actively involved in the care and education of children in the extended family. Children, raised in a protective and supportive environment, are expected to be obedient and respectful of elders. Hard work and achievement are encouraged. Adults of Mexican heritage expect the next generation to be more successful than the previous one. For the most part, personal matters are handled within the family and it is not unusual for older male children to discipline younger siblings.

Mexican people of all educational and socioeconomic levels use folk healing along with biomedical interventions. Financial resources are an important factor in deciding from whom and when a family seeks medical care. The ill person is expected to assume a passive role and family interdependence reigns; thus, self-care may not be an appropriate sick role. In the Mexican culture, health (illness) is believed to be a matter of fate (*distino*) or God's will (*las manos de Dios*). Physiologic abnormalities and disease process are influenced by imbalances in hot and cold and *currendaros* attempt to correct the imbalance through prayers, pledges to religious and supernatural forces, rituals (often involving candles, eggs, animal body parts, and other natural substances), and the administration of herbal teas, poultices, and baths. *Currenderas* (female) are believed to have been chosen by God to heal.

In regions with a large Mexican American population, cultural healers often are listed in telephone directories as "ethnopsychologists" or "ethnotherapists" alongside other mental health providers. *Yerbalists* (herbalists) use practices that date back to the pre-Colombian era. *Sobadoras* (masseuses) are female healers who use massage or manipulation of the bones to correct musculoskeletal imbalances. Frequently, *sobadoras* also are *parteras*, skilled in external rotation of the fetus from breech to head-down position. In this predominantly Catholic population, birth control (other than rhythm methods) is

not popular, and a Mexican American may not be comfortable discussing this topic with health professionals.

With the exception of narcotics, barbiturates, and addictive drugs, sale of pharmaceutical products is for the most part unregulated in Mexico. Associated with poverty and cultural beliefs related to healing, self-medication is widely practiced by this population. Products that require a physician's prescription in the U.S. often can be purchased over the counter in Mexican drugstores. Intravenous solutions (*seuros*) also can be purchased in this way, and it is not unusual for the family or a healer to administer *seuros* to a sick person in the home. It is not unusual for someone living in the U.S. to have relatives living in Mexico purchase and send medicinal products to them. Nor is it unusual for U.S. residents to travel to Mexico to make large purchases of pharmaceutical products (available only by prescription in this country) at considerably less cost than in this country.

Severity of an illness often is determined by intensity of pain and/or the appearance of blood among Mexican Americans, who are quite stoic when in pain. When offered a pain intervention they may refuse. Partly this response is steeped in the belief that silent suffering is a means of atoning for a wrong committed in the past. Traditional healing practices are passed by word of mouth, from mother to daughter and so on. Such practices continue to be widely used by Mexican Americans living in the U.S. for minor medical, psychological, and chronic health problems.

The traditional diet of Mexicans was naturally nutritious and low in fat. The introduction of fast foods (U.S.-style) into their diet, however, has presented serious health risks for Mexican Americans, in particular, obesity, diabetes, tuberculosis, and hypertension. Migrant farm workers from Mexico have substantially poorer health and shorter life spans than individuals of Mexican heritage who were born in the U.S. Conversely, alcohol consumption, smoking, and drug use are reported to be more common among lower socioeconomic Mexican Americans who were born in the U.S. than in those born in Mexico and who migrated to this country. Readers are encouraged to review the bibliographic resources at the end of this chapter for additional information about Mexican American culture, health status in general, and Mexican migrant agriculture workers and their families in particular .

Puerto Rican

Puerto Ricans make up the second-largest ethnic group of the U.S. Hispanic/Latino population. (Figure 6.1) Even before Spanish merchants arrived (1830s) on the island, native inhabitants of what is now known as Puerto Rico migrated to the U.S. mainland (circa late 1400s). The title *Boricua* ("land of the brave lord"), originally given to the island by Tano Indians, is used with pride by modern-day Puerto Ricans. Puerto Ricans were given U.S. citizenship in 1898 (Jones Act) when American troops landed on the island, along with a commitment for mandatory military service. A unique culture evolved in Puerto Rico associated with the blending of Asian, Spanish, African, French, and American people (circa 1830 to 1997). Since 1940, more than 41,000 have immigrated annually to the U.S. mainland to seek better education and job opportunities and/or to

be reunited with relatives. In the past decade a few Puerto Ricans living in the U.S. have returned to their native land.

With each government change on the island, there tends to be change in its official language, Spanish or English. Most Puerto Ricans speak Spanish fluently and have varying levels of English proficiency. Metropolitan residents in Puerto Rico usually are more English proficient than counterparts in rural areas and recent immigrants to the U.S. Puerto Rico's educational system is similar to that of the United States; thus, English competency can be assessed based on a person's years of formal education. Puerto Ricans are known to be affectionate (*carinosos*), hospitable (*simpatico*), and likeable. Relationships are important, and Puerto Ricans expect a respectful environment and health care providers to be soft-spoken. In establishing rapport, more time may needed for completing examinations and obtaining the health history. Out of respect and gratitude, it is not unusual for clients of this heritage to share home-cooked (traditional) foods with their caregivers.

Both nuclear and extended family (*la familia*) are highly valued by Puerto Ricans. Generational variations exist when it comes to decision making and designating the family spokesperson. For example, out of respect for their wisdom, grandparents (*abuelo/abuela*) and sometimes godparents (*compares/comadres*) are consulted by younger family members prior to making a decision. In some families, the oldest son or daughter holds a power position; hence, he or she becomes the spokesperson and final decision maker. In other families, older women assume that powerful and respected role. In younger families, men often assume decision-making responsibilities. In regard to woman's health issues, the husband may need to be consulted to obtain verbal consent for medical procedures to be performed on her.

Puerto Rican women have an active role in child rearing and caretaking of ill family members. Men provide financially and are expected to assume a passive role in child rearing and caretaking. Children are the center of the family. Emphasis is placed on teaching them respect, pursing a good education, and adhering to family religious belief systems. In most families, males are socialized to be more independent (*macho*) while girls are taught domestic responsibilities. Mothers usually discipline the children using both positive and negative rewards and, in some cases, corporal punishment. When the wife (mother) must work outside of the home, social and emotional conflicts often arise associated with traditional gender role expectations and role overload. Families struggle with the acceptance of homosexuality; thus, alternative sexual preferences usually remain undisclosed to avoid rejection.

Puerto Ricans have a relative perception of time that can interfere with keeping appointments. Some find it difficult to adhere to a predetermined time limit for an appointment, such as 15 or 30 minutes. Rather, the quality of the interaction with the caregiver is deemed more important than length of the visit. Puerto Ricans tend to have a serene world view of life and believe spiritual forces are in control of life and death ("as God desires" [*si Dios quiero*]), and this influences care-seeking behaviors and, ultimately, health status.

Most people of this heritage are open to expressing ailments and discomforts with health professionals in a private setting. Modesty is highly valued by both genders, and sexuality issues such as infertility, birth control, impotence, and sexually transmitted diseases are difficult to disclose to another person. Interestingly, the word "sex" is not used in their language; rather, "intimate relations" (*tener relaciones*) is used in reference to it. A health care provider of the same gender is preferred; if not feasible, someone of the same gender should remain in the room at all times. Pharmacists have an important role and often are consulted before going to the doctor. In fact, pharmacists are consulted about routine "daily" health matters for the entire family. Men tend to resist health-promotion and screening activities, but women (wives and mothers) can be highly influential in changing their behavior.

Health is viewed as the absence of mental, spiritual, and physical discomfort. A healthy person is happy and oversized, with rosy cheeks. One who is excessively worried (*nervioso/nervosa*) is considered to be ill as is the person who is "too thin" and not clean (*llenitos y limpos*). Among Puerto Ricans, *llenitos y limpos* symbolizes economic disadvantage. Several factors are associated with the onset of illness, including an outcome of sin, lack of personal attention for health, heredity, and sometimes evil (negative) environmental forces within the afflicted person. Genetic defects create great stress, and the mother often is blamed for such conditions when they occur in a child. Some in the extended family would argue the woman did not take appropriate care of herself while pregnant with the child. Mental illness, in particular, caries great stigma and a family may not disclose past or present experiences with such conditions. Often the terms *nervioso* or *ataque de nervios* (nervous attack) are used in reference to emotional or psychiatric conditions. Some believe that extreme suffering (*sufferimientos*) is a precursor to mental illness. When it comes to pain, Puerto Ricans are quite expressive and sometimes outspoken. *Ay bendite!* is a common expression of someone in severe pain (*dolar*). Along with western medical interventions, herbal teas, heat, and prayer are used to manage pain.

Puerto Ricans are very religious and *si Dios quere* (if God wills) is a commonly used phrase in day-to-day conversations. The majority practice Catholicism and a few are Protestants of various denominations. The extended family often expects the priest to bless a patient before surgery or special procedures, administer sacraments to someone who is very ill, and welcome a new baby into the family. Religious days often are national holidays as well. These are solemn occasions, usually associated with food prohibitions and certain daily activities, such as not eating meat, washing hair, or bathing. For persistent problems, some blend Native American, African, and Catholic beliefs (*espiritismo*) rituals to communicate with spirits. This practice has declined in use. Even those who do not use one, however, respect the power of an espiritista, who uses tropical herbs, aromatic ointments, and prayers to bring about healing. For additional information about Puerto Rican culture and healing practices refer to the bibliographic resources for this chapter.

Cuban

Another predominant community of Hispanics/Latinos living in the United States is of Cuban origin. (Figure 6.1) Cubans first arrived in Florida around 1800 to work in the

tobacco industry. The largest influx of immigrants occurred from 1959 to 1979 with the establishment of Fidel Castro's communist government. From 1980 to the present, there has been continuous immigration of Cubans to join relatives living in U.S. *Enclaves* (communities that sustain the language and culture) of Cubans are located in New York City, Tampa, and Miami.

The title "Cuban" is used in reference to both native-born and American-born people. As a group they are proud of their heritage and see no need to identify themselves as American or American Cuban; they simply refer to themselves as Cuban. This population mostly consists people who are of mixed-race (*mulattos*), whites, and blacks. Their predominant language is *Castellón* (common) Spanish. Cubans speak quickly, shorten words by dropping letters, and incorporate many English words not used in other Spanish dialects. American-born Cubans often are bicultural and highly fluent in both English and Spanish. Recent immigrants may speak very little English. Typically, Cubans speak quite loudly, are outgoing and confrontational, and use expansive hand gestures to add emphasis and drama to a conversation. Unlike Mexican Americans, Cubans expect direct eye contact. Not doing so is perceived as lack of respect or even dishonesty. Commands and requests are direct while silence infers uncertainty in the Cuban culture. To an outsider, conversations among Cubans may be (mis)perceived as hostile and aggressive.

Orientation to time varies with the length of time an individual has lived on the U.S. mainland, educational level, and socioeconomic status. Most Cubans live by Western business values, which emphasize the future, hard work, and competition. More traditional elderly people and recent U.S. immigrants may have a past time orientation and express the dream of returning to Cuba.

For Cubans, too, family is very important and often several generations live in the same household. The father and eldest son and/or daughter usually are the most educated. In turn, they are consulted by family because of their education and the respect given to elders, especially to males. Reconstituted families are uncommon. Individuals with homosexual preferences usually are closeted and not tolerated by other family members. There is a strong emphasis and respect for education. Men, expected to make decisions and protect the family, are quick to show anger and aggressive behavior (*machismo*). Male children are taught to be aggressive, competitive, and in control and to protect family honor and interests. Sons are especially protective of mothers. Women, expected to be submissive and primarily involved in family concerns, provide care to the sick. Female children are taught to be submissive, supportive, and caring. Corporal punishment is commonly used and respect of elders is stressed. Elders assist in care of children; in turn, children are expected to care for elder family members in the home until death.

The majority are Catholic, but other Christian denominations are represented within the Cuban community. After Castro assumed power, the state became more secular; now fewer people espouse Catholicism. In general, Cubans rigorously abide by traditional Catholic practices. An undetermined number practice an African-based voodoo religion (*Santaria*). Among them, when someone is chronically ill or under emotional duress or

western medicine is to no avail, assistance may be sought from a *Santaria*. This spiritual healer uses magic, spells, and animal sacrifices for rituals conducted in the client's home. The Santaria may also prescribe a particular ritual and/or the wearing of an amulet for a designated period of time to resolve the persistent condition.

Physical appearance is important to traditional Cubans, who see the somewhat overweight person with rosy cheeks as being healthy. Conversely, a person who is thin or seemingly underweight is deemed to be sickly, poor, or suffering from a "wasting" condition (e.g., depression, Tuberculosis, HIV/AIDS). Cubans living in the U.S. for some time have adopted American fitness and health practices. Germ theory is understood but supernatural and emotional factors also are seen as possible causes for disease. For example, extreme nervousness or stress is attributed to poor overall health and certain illness. Supernatural forces (e.g., evil eye, magic spells) are attributed to causing more resistant conditions, which usually require a traditional healer to cure. Physicians are highly regarded, associated with their level of education. Cuban patients usually follow their doctors' recommendations. In this culture, a person who is ill is expected to be totally submissive and assume a passive role in decision making. Men especially fall into helplessness when they become sick. Expression of pain is highly acceptable and men seem particularly sensitive to it. Women generally are more tolerant of pain. Even though there is a fear of becoming addicted, injections are deemed to be a more effective form of analgesia than are oral medications. The sick often wear religious medallions, rosary beads, crosses, and/or amulets of various substances. Religious objects may be pinned to the bedding and statues or a small shrine may be placed in the patient's room. Review the bibliographic resources at the end of this chapter for additional information about the Cuban people and their culture.

SUMMARY

This chapter focused on Hispanics/Latinos, the second-largest — and fastest-growing — minority group. Demographic trends, socioeconomic issues, health status, and patterns of accessing health care were reviewed. Cultural and linguistic characteristics for the three predominant ethnic groups were examined, specifically, Mexican American, Puerto Rican, and Cuban. This information can be useful to develop culturally and linguistically appropriate interventions for clients of Mexican, Puerto Rican, and Cuban heritage and to learn about the beliefs and health practices of other Hispanic/Latino ethnic groups.

CHAPTER SIX

Discussion Questions

- Review census data for your state and community. Describe Hispanic/Latino immigration trends and patterns. Elaborate on specific ethnic groups: Where do they live? work? attend school? seek health care? What has been the impact of their presence for state/local health and human services? If possible, provide anecdotal information related to Hispanics/Latinos for each of the above situations.

- Describe demographic trends and patterns of Hispanics/Latinos in relation to the population as a whole in your state and with other minority groups in particular. Compare and contrast trends in rural and in urban areas.

- Identify policies and programs that exist or are needed in your catchment area to address the particular needs of Hispanics/Latinos. Suggest ways these programs or services can be designed to fit cultural and linguistical preferences of these clients.

- Describe health disparities that exist within the Hispanics/Latinos in your state and in your catchment area.

- Using the information in this chapter along with Chapter 2, interview at least two people of Hispanic/Latino heritage to learn more about their ethnicity, culture, health beliefs, and expectations of health care providers. How are their responses similar or different? Based on their information, how can services in your facility be modified to be more culturally and linguistically appropriate for Hispanic/Latino clients?

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http://www.cdc.gov/nchs/fastats/hisfacts.htm

Congressional Hispanic Caucus
http://www.chci.org

Hispanic Nurses Association
http://www.hispanicnurses.org

Hispanic-Serving Health Professions Schools Inc.
1411 K St. N.W., Suite 200
Washington, DC 20009
(202) 783-5262
www.hshps.com

Hispanic Scholarship Fund
http://www.hsf.net

Latino Web Pages (Latino search engine)
http://www.latinonetpages.com

Michigan Agriculture Migrant and Seasonal Farm Worker Program
discusses issues, legislation, policy; numerous links to other sites
http://www.michaglabor.org/index_agriculture2.jsp

Migrant Clinicians Network
P.O. 164285
Austin, TX 78716
(512)327-2017
www.migrantclinician.org

National Center for Farmworker Health
America's Farmworker's Home Page
P.O. Box 150009
Austin, TX 78715
(512) 312-2700

National Council of La Raza
nonprofit, nonpartisan organization established in 1968 to reduce poverty and discrimi-
nation and improve life opportunities for Hispanic Americans
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United Farmworkers Association
www.ufw.org

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Latin American and Caribbean Programming/Initiatives
www.wkkf.org

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http://mexicanculture.about.com

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Regents of the University of California
http://clnet.ucr.edu

PUERTO RICAN

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national nonprofit organization for education/leadership development of Puerto Rican
and Latino youth.
www.aspira.org

National Puerto Rican Coalition Inc.
www.bateylink.org

NYISE Puerto Rican History and Culture
www.nyise.org/caribe

Puerto Rican Culture
http://welcome.topuertorico.org/culture

Puerto Rican Studies Association
www.puertorican-studies.org/~prsa

CUBAN

Cuban American National Network
1223 S.W. Fourth St.
Miami, FL 33135
www.cnc.org

icuban.com — the Internet Cuban
http://icuban.com

cubanculture.com
http://www.cubanculture.com

Cuba links
http://www.si.umich.edu/CHICO/LAD/cuba.html

CHAPTER SEVEN

OBJECTIVES

After reading this chapter you should be able to:

- Appraise personal and family cultural preferences.

- Delineate the domains of cultural and linguistic competence.

- Complete a client cultural assessment.

- Identify barriers to the provision of cultural linguistically appropriate care.

- Implement interventions that are culturally acceptable and appropriate.

- Collaborate with clients in an ethnocultural manner to improve adherence with prescribed medical regimens.

- Integrate traditional, alternative, and Western practices into clients' plan of care.

- Compile a bibliographic resource list related to development of cultural linguistical competence among health professionals.

BECOMING CULTURALLY AND LINGUISTICALLY COMPETENT

OVERVIEW

This chapter presents information related to the development of cultural and linguistic competence at the individual level. Cultural-linguistic competence consists of a continuum of skills ranging from self-awareness, to awareness of others, to the integration of a client's belief systems and linguistic patterns into his/her plan of care. Developing cultural-linguistic competence is a non-linear process. Individuals proceed at their own rate based on life experiences, exposure to other ethnic groups, and a receptive attitude to learning about cultural differences. Appropriate and acceptable services for targeted consumers depends on caregivers who are culturally and linguistically competent.

Rationale

Most people prefer to be seen by a provider who shares similar cultural beliefs, but that is not always feasible. Preparing health professionals to understand the complex issues surrounding culture and health is a critical component of eliminating minority health disparities. Ethnicity, culture, and language, for instance, are factors that can affect whether a patient takes a proper dose of medication or even agrees to take a certain pre-scribed medication. Likewise, not using appropriate interpreter services could lead to the misdiagnoses of a patient with limited English skills; distributing a brochure with culturally insensitive health messages could discourage someone from using a much needed service. Cultural-linguistic competence embodies the knowledge, attitudes, skills, and protocols that allow an individual or system to render services across cultural lines in an optimal manner. It permits individuals to respond with respect and empathy to people of all cultures, classes, races, religions, and ethnic backgrounds in a manner that recognizes, affirms, and values the worth of individuals, families, and communities.

Domains of cultural-linguistical competence

Seven domains are associated with cultural linguistical competence.

Box 7.1

Continuum of Cultural-Linguistical Competence

Ethnocentrism	Believing one's own culture determines standards of behavior by which all other groups are to be judged.
Cultural awareness	Appreciating and being sensitive to another's values, beliefs, practice, lifestyle, and problem-solving preferences.
Cultural knowledge	Developing insights about the organizational elements and expectations of anther culture.
Cultural competence	Integrating awareness, sensitivity, and knowledge about another culture with provision of care that is accepted by the group.
Linguistical competence	Being comfortable with the cultural nuances and linguistic patterns of another ethnic group.
Enculturation	The process of acquiring knowledge and internalizing the values and beliefs of another culture.

Values and attitudes focuses on care providers' promoting mutual respect and awareness of varying degrees of acculturation among individuals within an ethnic group and recognition that client-centered perspectives can influence a client's response to health, illness, disease, and death.

Communications style focuses on care providers' having sensitivity, awareness, and knowledge about verbal, nonverbal, and written communication patterns among individuals in an ethnic group.

Community/consumer participation focuses on providers of care having continuous, active involvement with community leaders and members to improve health outcomes among people who live there.

Physical environment, materials, and resources focuses on providers of care establishing culturally and linguistically friendly environments that fit the preferences of targeted clients — for example, a clinic's interior design, pictures, posters, artwork, magazines, brochures, audio/video materials.

Policies and procedures focuses on incorporating cultural-linguistic principles in an institution's written policies, procedures, mission statement, goals, objectives, clinical protocols, and orientation materials. (Chapter 8) Targeted consumers are actively involved in developing and evaluating outreach programs. An institution's vision should ensure that services and providers reflect the ethnic makeup of the targeted community. Box 7.9 consists of a tool, "Promoting cultural diversity and cultural competency: Self-assessment checklist for personnel providing services and support to children

with special needs and their families." This instrument lends itself to other types of services across the health care continuum.

Population-based clinical practice focuses on having skilled clinicians who are able to apply scientifically based interventions — tailored to fit consumers' cultural preferences. Care providers are familiar with social and political influences on other ethnic groups, appreciate their world views, and avoid stereotyping individuals of other ethnic origins. Box 7.8 presents such a tool, "Multicultural competence self-assessment for HIV prevention service providers." This questionnaire lends itself for use in other specialty services delivered in a range of settings across the health care continuum.

Recruiting, education, and professional development focuses on preparing culturally and linguistically competent providers and bringing minorities into health professions. (Appendix C)

Cultural-linguistical competence: A continuum

Box 7.2

Process of Developing Cultural-Linguistical Competence

- Reflect on personal cultural and ethnic preferences related to health and healing.
- Understand own ethnic and cultural background.
- Acknowledge another culture and its values, belief systems, and health-related preferences.
- Recognize that diversity is not synonymous with cultural inferiority.
- Learn about other cultural beliefs and preferences.
- Become aware of diversity in the community, workplace, and with clients.
- Assess (routinely) clients' ethnic and cultural preferences related to health beliefs.
- Implement strategies that address clients' cultural barriers to care.
- Deliver services that are ethno-culturally appropriate and acceptable to clients.
- Integrate traditional healing practices with western medicine as opportunities arise.
- Evaluate care/services to assess level of cultural and linguistic competency.
- Advocate for clients who are culturally vulnerable.
- Adapt care to fit with a client's cultural framework and linguistic style.

Sources: www.omhrc.gov & NCCC

Cultural-linguistic competency can be characterized as a continuum of skills. (Box 7.1) At one end of the continuum, *ethnocentrism* refers to the prejudicial belief that one's own group determines the standards for behavior by which all other cultural groups are to be judged. At this level, behaviors and beliefs of other cultural groups are devalued or treated with suspicion or hostility. The next level is *cultural awareness*, which is an appreciation of and sensitivity to another's values, beliefs, practices, lifestyle, and problem-solving preferences. Next is *cultural knowledge*, where one gleans insights about the organizational elements and seeks information on strategies to provide care that is acceptable and appropriate for another culture. *Enculturation* describes the process of completely acquiring and internalizing the values and beliefs of another culture. *Cultural competence* means one possesses a repertoire of skills that can be used to provide appropriate and acceptable care, even if it the cultural preferences are not congruent with personal preferences. At the opposite end of the continuum is *linguistic competence*. This involves the ability to communicate with someone who speaks another language and being sensitive to the cultural nuances associated with their verbal and nonverbal communication patterns. As with other skills, culturally based interventions must be refined and modified with changing life experiences and exposure to others' belief systems. Box 7.2 highlights the process of developing cultural linguistic competence at the individual level. Essentially, cultural competence progresses from personal awareness and cultural sensitivity to a more sophisticated understanding of the belief systems of individuals who are of another ethnic group.

Self-appraisal

Before becoming sensitive to and accommodating another's cultural beliefs and values, the health care provider must first understand something about his or her own culture and ethnicity. Self-appraisal implies reflecting on the manner in which ethno-cultural origins affect personal beliefs, behaviors, and ways of interacting with diverse people on a professional and personal level. A self-appraisal can lead to insights about personal expectations of people when they are ill. Subsequently, the two sets of culturally based expectations can be compared and contrasted, and then the person identifies and deflects potential conflicts. Box 7.3 includes examples of questions that can be used for self-appraisal.

Exposure to diverse groups

Following self-awareness, the health care provider can expand interest to people who are of another ethnic background. Information on diverse groups is readily available on the Internet and augmented by interacting with people in their natural setting. An open and nonjudgmental attitude is critical to learning about diverse belief systems. Talk with people having greater knowledge and experience. Ask questions! Most people enjoy telling other people about their cultural ways if the inquiry is made with an intent to learn. If possible, find out how and why specific rituals are used in everyday life situations and then proceed to health beliefs and care-seeking behaviors. Box 7.4 lists cultural characteristics that may differ between clients and health care providers. If not recog-

Box 7.3

EXEMPLAR: Cultural Self-Appraisal Questions

To accommodate others' values, health professionals first must understand their own culture. A self-appraisal is a useful tool to start the process. Reflect on the following questions: 1) How do these fit with your origins? 2) How do these fit with clients who are of another ethnicity or culture? 3) Identify differences between the two that could be a source of conflict in your practice.

- How do you identify yourself in terms of race, ethnicity, religious or political beliefs, and socioeconomic class?
- What has it meant to be part of that group?
- Describe the customs or traditions in your family of origin that expressed your heritage.
- What special foods, gifts, songs, and ceremonies were related to events such as birth, puberty, starting school, graduation, marriage, divorce, illness, hospitalization, and death?
- How were feelings of love and affection expressed in your family?
- How were feelings of anger, frustration, and sadness expressed in your family? What were the most valued and respected personal traits? Who was allowed to expressed those emotions?
- What has been the role of women and men in your family and culture? How were decisions made? Who had the final say in those decisions?
- What role was fate believed to play in a person's life?
- How were time, work, leisure, health, and illness defined and valued?
- For what, and how, was discipline used?
- Describe the role of religion and spirituality in your family. What practices were expected of individuals related to those beliefs (e.g., attending church on Sunday, going to weekly confession, baptism, communion, confirmation, minister visiting the home when one was ill).
- What was your first experience with feeling different?
- In your family, how was healthiness defined? What did individuals do to stay healthy?
- What factors contributed to illness? (pathogens, fate, lack of balance, etc.)
- What was expected of a family member when becoming ill? What interventions were used to treat illness?
- Who are the "healers" or health care providers in your family/community? Who decided when someone in your family needed to seek health care from them?
- Reflect on the answers you have given for these questions. Do you still adhere to any of these beliefs in your current living and working situations? Describe how these are similar or different from your family of origin.

Box 7.4

Cultural Characteristics that May Differ Between Providers and Clients

- Concept of time
- Definition of community
- Definition of family
- Childbearing and child-rearing preferences/patterns
- Role of criticism and praise
- Age and gender role expectations
- The meaning of possessions/wealth/poverty
- Relationship to the natural and supernatural world
- Sources of knowledge
- Expressions of knowledge
- Role of religion
- Definition of health; meaning/approach to illness
- Sources of authority
- Respect — who gives it? Who gets it? How is it expressed?
- Who is considered wise?
- How does one become wise?
- Importance of place
- Relationship of work and community
- Relationship with the unknown
- Personal needs — how are they identified? How are they respected?
- Concept of cooperation and competition
- Degree of openness versus preference for privacy
- How emotions are demonstrated
- Literacy/verbal abilities
- Cognitive abilities
- Observation skills

Sources: Materials from Office of Minority Health & NCCC

nized, cultural and linguistic differences can become sources of contention and could hinder delivery of appropriate care.

Community participation

Probably the most effective strategy is to interact with people of a particular background — *on their turf* (natural environment) — at social events as well as in their home. Even by becoming highly involved and subsumed in a community's social and political activities, it is not likely that an outsider will learn all the important facts about a cultural group before making at least a few blunders. One learns gradually by working within a community over a period of time. Through formal and informal discussions, a health

Box 7.5

Communicating About Cultural Differences

- Recognize there are differences between people.

- Understand each person has logical reasons for what he/she does.

- Develop cultural self-awareness. What did you think/feel/do, and how is that different from what you think the other person thought/felt/did?

- Describe and identify, then interpret cautiously what you think you observed or heard.

- Do not assume your interpretation is correct. Check it out with the other person's non-verbal messages.

- Develop insight and verbalize your own nonverbal messages. Don't assume the other person is interpreting them correctly.

- Share your experiences honestly. Use "I" statements to reinforce your experience with the event.

- Acknowledge any discomfort, hesitation, or concern you may have in communicating about differences. Be ready to recover if you offend the other person.

- Use your judgment about when, where, and how to communicate about differences to another person. Such situations can be perceived as either a crisis or opportunity for developing a working relationship.

- Give time and attention to communicating about differences (e.g., active listening, paraphrasing, clarifying questions, summarizing, conveying an attitude of willingness to learn about the other person's beliefs).

- Do not evaluate or judge a person who seems "different" from what you are accustomed to.

*Sources: Materials from www.omhrc.gov & NCCC

Box 7.6

Ethno-Cultural Barriers to Accessing Health Care

- Traditions of handling personal problems (e.g., such self-care practices as using over-the-counter medications, exercising, ingesting alcohol, resting, praying).
- Beliefs about the cause of a disorder and the appropriate healer for it (e.g., doctor, nurse practitioner, a neighborhood nurse acquaintance, chiropractor, herbologist, community lay healer, medicine man/woman, voodoo priestess, homeopathy, therapeutic touch, imagery, acupuncture/acupressure, curandero, shaman).
- Lack of knowledge about a physical or emotional disorder and the place of formal services in preventing or treating the condition (e.g., being stoic and suffering in silence rather then seeking supportive care; paying for emergency care rather then spending money on health promotion or primary prevention; expectations that one receives a prescription when paying to seek care from a doctor or nurse [antibiotic, analgesic]).
- Language barriers (e.g., English as the second language; functional illiteracy [reading below the 5th-grade level; Note: most health care literature is written at the 10th-grade level or higher]; nonverbal [cultural] nuances associated with terminology that is used in health education).
- Translation-/interpreter-related issues.
- Difficulty in maintaining confidentiality and anonymity in a setting where many residents are acquainted.
- Cultural insensitivity by providers or the health care delivery system.
- Confusion about publicly funded services or third-party payer mandates.
- Conflicting views regarding time perception.
- Misinterpretation of behaviors associated with space orientation.
- Previous experiences (negative in particular) with the health care system and providers.

Sources: materials from OMH & NCCC

professional can become knowledgeable about clients' preferred manner of interacting, their self-care practices, and use of alternative healers. Box 7.5 offers strategies to communicate about cultural differences with clients as well as peers.

It can be difficult to learn about people who are not part of a community's mainstream culture unless someone actively seeks out those (sub)groups. When establishing a practice it is important to assess the catchment area to define subgroups within the larger community. Some underrepresented groups are easy to identify because they are isolated by a geographical boundary, biological features, lifestyle, attire, religion, political

views, language, leisure activity, or occupation. For example, generally it is not difficult to identify an Amish or Mennonite group in the midwest, or a Puerto Rican or Asian community within a large city. There are other ethnic groups that may not be as geographically bound, such as Laotians, Vietnamese, Italians, Poles, Irish, Jehovah Witnesses, Orthodox Jews, Latter Day Saints, Seventh Day Adventists, or a smaller Native American tribe. Cultural perspectives of "less noticeable" groups are critical to ensuring that services that are rendered by the health care providers are appropriate and acceptable to those particular communities as well. Box 7.6 summarizes ethnocultural barriers experienced by clients of another ethnicity in accessing cultural and linguistically competent care. Box 7.7 includes questions that can be used to complete a cultural assessment on a client. This information can be used to develop interventions that fit that individual's cultural beliefs, linguistic preferences, and lifestyle.

Educating, recruiting, and retaining minorities to the health professions

One factor that contributes to cultural and linguistic insensitivity in the health care system is the very low number of minorities who enter the health professions. Historically, schools preparing health professionals have had a homogeneous student body, made up predominantly of Euro-Americans. In recent years, most schools have made a dedicated effort to recruit and retain minority students with varying degrees of success. By virtue of the dominant cultural representation, health professionals reflect attitudes of the greater majority, that being white middle-class. Educators are challenged to produce culturally competent clinicians as our society becomes increasingly diverse. Who can present the ethno-cultural perspective of a minority group in health care better than people who are of that background? Minorities must be encouraged to enter the health professions, and policies must be in place to support those efforts. Professionals of diverse origins who attain leadership roles are in ideal positions to serve as a role models to young people from their own communities. As partners, health care providers can learn together what constitutes culturally appropriate care for clients. Programs educating health professionals also must facilitate diversity in their faculty as well as in their student body. (Chapter 3, Chapter 4, Chapter 5, Chapter 6, Appendix D)

There is no quick fix to increase the underrepresentation of racial and ethnic minorities in the health professional workforce. A variety of federal, state, and local initiatives have been put in place over the past two decades to recruit, retain, and educate individuals of minority backgrounds to the health professions. These have meet with varying degrees of success. Three of the more effective federal-state-local partnership initiatives are highlighted in Chapter 1, specifically AHECs, HETCs, and the NHSC.

Elementary and secondary students who are of an ethnic and racial minority in particular must be encouraged to prepare for admission and success in health professions programs within institutions of higher learning. Links must be established between local educational systems, high schools, colleges, and institutions of higher learning. In other words, educational "pipelines" for minority children must begin in elementary school to strengthen students' background in the sciences. Likewise, opportunities for inquiry-

Box 7.7

Components of a Client Cultural Assessment*

- Name of client.
- How (by what name) does the client prefer to be referred?
- Birthplace of client, parents, & grandparents (paternal and maternal).
- Number of siblings of the client, parents, grandparents.
- Setting where client, parents, grandparents were raised (rural, urban, suburban).
- Nation/country where client, parents, grandparents were raised.
- Age upon coming to the U.S. (client, parents, grandparents as applicable).
- Native language of the client, parents, grandparents; to what degree is this spoken?
- Can the client speak, understand, and/or read English?
- When growing up, who lived with you (nuclear or extended family, others)?
- Who does the client identify as his/her family (individual members of the client system)?
- Significant other's culture, ethnic, and racial background (if applicable).
- Has the client maintained contact with other relatives (aunts, uncles, cousins; siblings; parents; one's own children)?
- Proximity of nuclear and extended family members' residence to client's home.
- Frequency of contact with nuclear and extended family (daily, weekly, monthly, once a year or less, never).
- Was client's original family name changed upon arriving in this country?
- Client's and spouse's religious preferences; do they belong to a religious institution/faith; are they active members?
- Frequency of attending religious services.
- Religious practices engaged in within the home (specify type and frequency).
- Type of school attended (public, private, parochial); level of education.
- Does client reside in a community where neighbors have similar education, racial, ethnic, cultural, and religious backgrounds?
- Are friends of similar backgrounds?
- Does client prepare foods related to ethnic background (describe)?
- Does client participate in ethnic/cultural activities (e.g., dancing, dress, holiday celebrations, rites of passage, music)?
- Specific cultural/ethnic practices engaged in that relate to lifestyle, health maintenance, illness, and health care-seeking behaviors.

Adapted from Geissler (1994) and Stanhope & Knollmueller (1997)

Box 7.10

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Select Resources for Ethno-Cultural Information

- International/national/local nonprofit institutions and organizations

- Federal and state government agencies

- State and local health departments

- Media reports/documentaries

- Community-based organizations

- Minority-owned consulting and communications firms

- Large public relations and advertising agencies

- Ethnic/minority organizations including faith communities

- Health professional organizations

- Internet-based search engines

- Bibliographies/reference sections of textbooks, journals, and recreational reading materials

</div>

based science instruction, seminars, and proposal development workshops must be created so students can engage in independent research that focuses on minority populations.

The Bureau of Health Professions reports a serious underrepresentation of racial minorities in faculty positions at health professions schools. Faculty of diverse cultural and ethnic backgrounds are needed to develop curriculum and assume leadership roles in framing clinical issues, research questions, and health policy. Diverse health professionals and educators are needed to serve as role models and strategists in recruitment and retention programs targeting minority students. Finally, health professionals of diverse backgrounds are needed to ensure that all perspectives are considered in policies developed at the local, state, federal, and international levels.

Assessing cultural-linguistical competence

In the past several years, a variety of tools (guidelines) have been published that can be used to assess level of cultural-linguistic competence in individuals, in a particular program, or for a specific population within a community-based program or an in-patient health care facility. Even though these tools focus on a particular group, the questions could be modified to fit many other situations. The information could be a starting point to create diversity and cultural awareness among individual employees, on a par-

Box 7.8

Multicultural Competency Self-Assessment for HIV-Prevention Service Providers
(Source: Office of Minority Health. Winter 2001. Multicultural competency: Creating cultural competency. HIV Impact. pp. 8-9.)

Multicultural competency is a commitment to: a) exploring the influences of one's own culture or cultures, b) understanding ways in which groups of people have been, and are, treated in society, and c) developing knowledge and skills to provide effective HIV prevention services for people who are diverse in terms of gender, age, race, ethnicity, sexual orientation, religion, HIV status, primary language, disability, etc. This survey provides a tool for you to assess your multicultural competency and to guide discussion among HIV-prevention service providers about ways in which you can increase your effectiveness in providing HIV-prevention services for diverse individuals.

Rate your level of multicultural competency on a scale from 1 (not at all) to 5 (extremely).

CULTURAL AWARENESS

1. I recognize the influence of my own culture(s) on my actions and thoughts.
   1   2   3   4   5

2. I am aware of my life experiences as a person related to a culture (or multiple cultures).
   1   2   3   4   5

3. I have assessed my involvement with people of other cultures.
   1   2   3   4   5

4. I have contact with individuals, families, and groups of people reflective of other cultures.
   1   2   3   4   5

KNOWLEDGE

5. I am knowledgeable about the community, demographics, history, problems, and strengths of the social and cultural groups of individuals with whom I work.
   1   2   3   4   5

6. I know that diversity within cultures can be as important as diversity between cultures.
   1   2   3   4   5

7. I am knowledgeable about the sexual cultures (and nuances of these cultures) of the individuals with whom I work.
   1   2   3   4   5

8. I am knowledgeable about drug use in the context of sexual expression of the individuals with whom I work.
   1   2   3   4   5

9. I am knowledgeable about the following factors and their relationship to HIV/AIDS prevention and risk behaviors:
   a. racism
   1   2   3   4   5

   b. sexism
   1   2   3   4   5

   c. classism
   1   2   3   4   5

   d. heterosexism
   1   2   3   4   5

   e. homophobia
   1   2   3   4   5

Box 7.8 - continued

f. ageism

1   2   3   4   5

g. HIV status

1   2   3   4   5

10.   I am knowledgeable about alcohol and other drug use related to HIV/AIDS among the individuals with whom I work.

1   2   3   4   5

11.   I am knowledgeable about mental health related to HIV/AIDS among individuals with whom I work.

1   2   3   4   5

SKILLS

12.   I express concern for, interest in, credibility, and competence to the individuals with whom I work.

1   2   3   4   5

13.   I show respect for the unique and culturally defined strengths of various individuals.

1   2   3   4   5

14.   I show respect for the unique and culturally defined needs of various individuals.

1   2   3   4   5

15.   I am able to work with the multiple roles and identities of individuals.

1   2   3   4   5

16.   I am able to advocate for individuals (and on my clients' behalf).

1   2   3   4   5

17.   I am able to identify resources, assets, and strengths within a community.

1   2   3   4   5

18.   I am able to help clients personalize their risks of HIV transmission.

1   2   3   4   5

19.   I am able to help individuals build upon their strengths to reduce HIV transmission risks.

1   2   3   4   5

COMMITMENT TO INCREASING MULTICULTURAL COMPETENCY

20.   I have identified specific ways to increase my multicultural competence.

1   2   3   4   5

CONCLUSIONS

21.   What are your strengths, or what do you do well, when working with people who are different than you?

22.   What are your biggest challenges when working with people who are different than you? What makes you most uncomfortable?

23.   What would be helpful to increase your comfort and ability to work with people who are different?

Developed by the Wisconsin HIV Prevention Community Planning Council and faculty at the University of Wisconsin at Madison (1999). For more information about the assessments, contact

Dr. Cox or Molly Herrmann
Wisconsin HIV/AIDS Program Community Planning Coordinators
(608) 267-6730

Box 7.9

Promoting cultural diversity and cultural competency: Self-assessment checklist for personnel providing services and support to children with special needs and their families*

Tawara D. Goode

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment.

Directions:

Select A, B, or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I rarely or never do

PHYSICAL ENVIRONMENT, MATERIALS, & RESOURCES

_____ 1.   I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2.   I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the cultures of children and families served by my program or agency.

_____ 3.   When using videos, films, or other media resources for health education, treatment, or other interventions, I ensure that they reflect the cultures of children and families served by my program or agency.

_____ 4.   When using food during an assessment, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5.   I ensure that toys and other play accessories in reception areas and those used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

COMMUNICATION STYLES

_____ 6.   For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.

_____ 7.   I attempt to determine any familial colloquialisms used by children and families that may impact an assessment, treatment, or other interventions.

_____ 8.   I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9.   I use bilingual staff or trained volunteers to serve as interpreters during assessments, meetings, or other events for parents who would require this level of assistance.

_____ 10.   When interacting with parents who have limited English proficiency I always keep in mind that:

_____ * limitations in English proficiency in no way reflect their level of intellectual functioning.

_____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate in their language of origin.

_____ * they may or may not be literate in their language of origin or English.

_____ 11.   When possible, I ensure that all notices and communiques to parents are written in their language of origin.

_____ 12.   I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

VALUES & ATTITUDES

_____ 13   I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

Box 7.9 - continued

_____ 14. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.

_____ 16. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice.

_____ 17. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____ 18. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 19. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).

_____ 21. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 23. I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.

_____ 24. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.

_____ 25. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 26. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____ 27. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 28. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 29. I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and families.

This document, developed by the National Center for Cultural Competence (NCCC) was designed to assist meeting and conference planners to infuse themes related to cultural and linguistic competence by Tawara D. Goode. Georgetown University Child Development Center-UAP. Permission is granted to reproduce this document for distribution so long as credit be given to the NCCC.

ticular unit, or in an entire organization. The items included in the various tools could provide a snapshot or benchmark of multicultural competency in a person, unit, or facility — at one point in time. A self-appraisal (assessment) could be repeated (e.g., biannually, annually) to monitor individuals and agencies, increasing one's ability to serve diverse individuals. An assessment tool could also be used for educating, guiding discussions on multicultural issues, or developing individual and/or group work plans. Prior to administering the assessment, determine how the results will be used. For instance, the results could be shared within the group, or anonymously completed and reported as group data. (Box 7.8, Box 7.9, Box 7.10)

SUMMARY

This chapter presented an overview of the process for becoming culturally and linguistically competent at the individual level. Domains of cultural-linguistic competence were highlighted, along with self-appraisal tools that can be used to measure these skills. The questionnaires could be used to obtain baseline data on individuals and/or groups, to promote awareness of diversity, and to measure outcomes of programs having that focus. Appropriate and acceptable services for diverse consumers in a catchment area will depend on caregivers who are culturally and linguistically competent.

CHAPTER SEVEN

Discussion Questions

- Analyze the interrelatedness of race, ethnicity, and culture with socioeconomic factors for minority groups in your market area.

- Of what importance is cultural and ethnic diversity in the health care delivery system in general? In your health care facility? For your particular unit or department?

- Reflect on demographic and population trends in the U.S. How might these impact health care delivery in the U.S., and for your particular discipline, within the next decade?

- What population changes are projected for your geographical catchment area, and how could they affect your practice?

- Identify a minority or underrepresented group in your practice setting. What are some of the ethno-cultural practices related to their health beliefs and health care-seeking behaviors?

Discussion Questions

- How can cultural assessment questions be incorporated into your facility's or department's current policies and procedures for client admissions?

- What self-care practices do you and your family use? Are these for health promotion, illness prevention, or symptom treatment? How could your beliefs impede or enhance professional treatment interventions for clients who are of another culture or ethnicity?

- Appraise your level of cultural linguistical competence using the information presented in Boxes 7.1, 7.2, 7.3, 7.4, and 7.9. Using the data from the self-assessments, develop a plan to increase your level of cultural-linguistic competence. Where on the continuum would you rate yourself? What are your strengths? What areas need further development? What must you do to become fully culturally and linguistically competent (e.g., take a college course, attend workshops, read up on a particular group, travel to another country)?

- Identify a group that is vulnerable or has special needs within your community. Present demographic data for the group. Describe why the members could be at risk for certain health problems. Are any interventions being implemented by your facility or department to prevent or respond to those particular group concerns? Please elaborate.

- Complete a cultural assessment with a client of another ethnic background using the information in Box 7.7. Discuss your findings with another professional peer. (Box 7.5) Begin a resource file (or add to an existing database) for your unit or department focusing on that particular culture or ethnic group.

- Using the questions in Box 7.9, undertake an assessment of your unit or department to appraise its degree of cultural and linguistical appropriateness relative to the clients that you serve. What are your strengths? What areas need refinement? What must be done/changed to be cultural and linguistically competent (e.g., have pictures and materials that reflect the racial group being served; translate existing educational materials, consent forms, posters; have staff members that reflect the ethnic makeup of consumers)?

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www.aamc.org

Association of Clinicians for the Underserved
501 Darby Creek Road, Suite 20
Lexington, KY 40509-1606
(606) 263-0046
www.clinicians.org

Bureau of Primary Health Care —Health Resources and Services Administration
4350 East-West Highway
Bethesda, MD 20814
(301) 594-4100
www.bphc.hrsa.gov

Cross Cultural Health Care Program
Pacific Medical Clinics
1200 12th Ave. S.
Seattle, WA 98144
(206) 326-4161
www.xcukure.org

Division of Health Professions Diversity
(a unit of HRSA's Bureau of Health Professions)
http://bhpr.hrsa.gov/dhpd/home.htm

Hispanic Nurses Association
http://www.hispanicnurses.org

Hispanic-Serving Health Professions Schools Inc.
1411 K St. N.W., Suite 200
Washington, DC20009
(202) 783-5262
www.hshps.com

Indians into Medicine (INMED) Program
University of North Dakota School of Medicine
P.O. Box 9037
Grand Forks, AND 58202-9037
(701) 777-3037
www.med.und.nodak.edu/dept/inmed/home.htm

Migrant Clinicians Network
P.O. Box 164285
Austin, TX 78716
(512) 327-2017
www.migrantclinician.org

National Agenda for Nursing Workforce Racial/Ethnic Diversity
www.bhpr.hrsa.gov/dn/nacnep/diversity.htm

National Black Nurses Association
www.nbna.org

National Center for Cultural Healing
2331 Archdale Road
Reston, VA 20191
(703) 264-1994
www.culturalhealing.com

National Center for Cultural Competence (NCCC)
Georgetown University Child Development Center
www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html

National Rural Health Association
One West Armour Blvd, Suite 203
Kansas City, MO 64111
(816) 756-3140
(816) 756-3144
www.NRHArural.org

Philippine Nurses Association
www.pna-america.org

RN Advocate
www.rnadvocate.com/nursing.htm

CHAPTER EIGHT

OBJECTIVES

After reading this chapter you should be able to:

- Appraise the cultural characteristics of populations served by your institution / facility.

- Analyze population trends and their impact on the local health care delivery system.

- Explore and design innovative approaches for provision of culturally and linguistically competent care by staff in your facility.

- Evaluate cultural-linguistical competence in care rendered to clients / consumers of your services.

- Compile a bibliographic resource list related to development of culturally and linguistically appropriate programs / services at the organizational level.

Implementing Cultural-Linguistical Competence at the Organizational Level

Overview

This chapter presents information on the development of cultural and linguistic competence at the level of the organization. To be reviewed is the process for getting started, planning, implementing, and evaluating a cultural-linguistic sensitivity program. Several tools and checklists are included to facilitate the process. Effective organizations incorporate their clients' diversity into their services. Culturally and linguistically competent organizations and institutions collaborate with knowledgeable community members at every phase of program operation — design, implementation, and evaluation. The process must involve administrators, clinicians, staff members, and clients — working as partners — to enhance program integrity and clarify communication. The result of a culturally and linguistically competent organization is sound interventions that are cost effective along with improved health outcomes.

Rationale

Nationwide, organizations of all types are struggling with the challenges and opportunities to respond effectively to the needs of individuals and families from racially, ethnically, culturally, and linguistically diverse backgrounds. (Chapter 1) There is no one method for getting started. Individuals, departments, programs, and organizations are at various levels of awareness along the cultural-linguistic competency continuum. They have varying departure points along with projected time frames for achieving specific goals and outcomes. Cultural-linguistic competence at the organizational level is achievable when program designers work closely with knowledgeable people from the targeted community to develop services that reflect their diverse values, traditions, and customs. The partnering process adds value by enhancing the quality of health care delivery, along with improved outcomes, client satisfaction, retention of covered lives and profit margins. (Appendix A, Appendix D)

Program planners are advised to seek out models that worked in similar organizations and discuss programmatic details and how they might be adapted to fit the organi-

Box 8.1

Getting Started: Planning, Implementing, and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings *

- Convene a cultural competence committee, work group or task force within your program or organization. This group should have representation from policy making, administration, practice/service delivery and consumer levels and reflect the diversity within the program or organization and the community at large. The group can serve as the primary body for planning, implementing and evaluating organizational cultural competence initiatives.

- Ensure that the program's or organization's mission statement commits to cultural competence as an integral component of all of its activities. The mission statement should articulate principles, rationale and values for culturally and linguistically competent health care service delivery. The cultural competence work group should be involved in or facilitate the development of this statement.

- Determine the racially, ethnically, culturally and linguistically diverse groups within your geographic locale served by your program or organization. Assess the degree to which these groups are accessing services and the level of satisfaction with the services received.

- Determine what percentage of the population that resides in the geographic locale served by your program or organization is affected by the following six health disparities: cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations.

- Collaborate with consumers, community-based organizations and informal networks of support to develop approaches for delivering preventive health messages in a culturally and linguistically competent manner. This collaborative process can help to inform your program or organization of adaptations to service delivery that respond to the needs and interests of diverse populations.

- Conduct a comprehensive program or organizational cultural competence self-assessment. Determine which instrument(s) and/or consultant(s) best match the needs and interests of your program or organization. Use the self-assessment results to develop a long-term plan, with measurable goals and objectives, strategies and fiscal resources. This plan should allow for the incorporation of cultural and linguistic competence into all aspects of your program or organization. This may include, but is not limited to, changes in the following: mission statement, policies, procedures, program administration, staffing patterns, position descriptions, personnel performance measures, professional development, pre-service and inservice training activities, service delivery practices, strategies for outreach, telecommunications and information dissemination systems.

- Conduct an assessment of staff to determine their perceived staff development needs that will enable them to provide services to racially, ethnically, culturally and linguistically diverse groups.

Box 8.1 - continued

- Convene focus groups or use other approaches to solicit consumer input on professional or staff development needs related to the provision of culturally and linguistically competent health care.

- Network and dialogue with other programs or organizations, concerned with primary and community-based health care, that have begun the journey towards developing, implementing and evaluating culturally competent service delivery systems. Adapt their processes, policies and procedures and other information to meet your program's or organization's needs and interests. Encourage partnerships and establish mechanisms to share training resources at the local, state or regional levels.

- Seek resources from federally and privately funded technical assistance centers that catalog information on cultural and linguistic competence, primary health care, and health care issues specific to racially, ethnically, culturally and linguistically diverse groups (e.g., treatment, interventions, how to work with natural healers, outreach approaches, consumer education programs).

- Convene informal brown bag lunches or other forums to engage program or organization personnel in discussions and activities that offer an opportunity to explore attitudes, beliefs and values related to cultural diversity and cultural and linguistic competence.

- Identify and include budgetary expenditures each fiscal year for resource development and professional development through participation in conferences, workshops, colloquia and seminars on cultural and linguistic competence and other issues related to primary and community-based health care.

- Gather and categorize resource materials related to primary health care and culturally diverse groups for use as references by program or organization personnel.

- Build and utilize a network of natural helpers, community informants and other "experts" who have knowledge of the racially, ethnically, culturally and linguistically diverse groups served by your program or organization.

- Network with advocacy organizations concerned with specific health care, social and economic issues impacting racially, ethnically, culturally and linguistically diverse communities. Solicit their involvement and input in the design, implementation and evaluation of primary and community-based health care service delivery initiatives at the local, state, regional and national levels.

Box 8.2

Strategies for Implementing Culturally and Linguistically Appropriate Community-Based Programs/Services

- Learn about the community (market area) and the people who live there from multiple sources, including families and individuals who will use the program.

- Recruit community members to be involved in determining needs and possible approaches to address these concerns.

- Review what has been done in other communities with similar populations.

- Identify and agree on priority areas to be targeted on the basis of professional and community knowledge and experience.

- Include members of the target population in the design and delivery of the services.

- Evaluate the program on the basis of the process (formative evaluation) and outcomes in the targeted population and the community's priority goals.

- Involve community members in ongoing evaluation efforts.

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zation. The National MultiCultural Institute (http://www.nmci.org) and the National Center for Cultural Competence have published guidelines that can assist an organization in creating a diversity program and designing and delivering culturally and linguistically appropriate services. Box 8.1 is a tool titled "Getting Started: Planning, Implementing, and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings." Box 8.2 includes additional strategies that have proven useful for implementing culturally and linguistically appropriate community-based programs/services. Box 8.3 is a check listto facilitate the development of linguistic competence within primary health care organizations. Even though their focus is primary care, the information included in the three instruments can be adapted and used in other specialty areas across the health care continuum.

Creating institution-wide cultural-linguistical competence
http://www.omhrc.gov

Achieving a culturally and linguistically competent organization takes commitment, time, and planning along with employee and community involvement. The next section highlights major steps in the process in achieving that organization-wide goal.

Define diversity

Organizations planning a cultural-linguistic competence program should first understand what the term "diversity" implies and then examine its relevance to their market area. Some mistakenly equate diversity with affirmative action. Others mistakenly

Box 8.3

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations

The following checklist can be used to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence. * **

Does the primary health care organization or program have:

❏ A mission statement that articulates its principles, rationale, and values for providing linguistically and culturally competent health care services?

❏ Policies and procedures that support staff recruitment, hiring, and retention to achieve the goal of a diverse and linguistically competent staff?

❏ Position description and personnel performance measures that include skill sets related to linguistic competence?

❏ Policies and resources to support ongoing professional development and in-service training (at all levels) related to linguistic competence?

❏ Policies, procedures and fiscal planning to ensure the provision of translation and interpretation services?

❏ Policies and procedures regarding the translation of patient consent forms, educational materials, and other information in formats that meet the literacy needs of patients?

❏ Policies and procedures to evaluate the quality and appropriateness of interpretation and translation ser vices?

❏ Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that are provided?

❏ Policies and resources that support community outreach initiatives to persons with limited English proficiency?

❏ Policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services?

Definitions:
The terms interpretation and translation are often used interchangeably. The National Center for Cultural Competence makes a distinction between the two and provides the following definitions: "Translation typically refers to the written conversion of written materials from one language to another. Interpretation is the oral restating in or language of what has been said in another language."

*** Source: National Center for Cultural Competence. January 2001. Linguistic competence in primary health care delivery systems: Implications for policy makers. Policy Brief 2.*

Box 8.4

Parameters of Culture that Determine Appropriate and Acceptable Care*
parameter — defined as a constant that has a given value in one context but a different meaning in another)

Presence. How we appear, how we move about, what we sound like (regardless of what we are wearing or saying) may be termed presence. Poise, glance, angle of chin, gait, voice quality, smile, and laughter all are highly personal matters, yet they are to a great extent affected by the culture in which we live and our position in it.

Language. Language makes culture possible. Born with the capacity for language, the infant is able to learn it only through contact with those who already know it, and it soon becomes and remains an inseparable part of them. A person's place in her culture depends in great part upon her knowledge of and use of language.

Gesture. Bodily movements, as of the head and hands, frequently accompany and reinforce speech and often are used alone. The meaning of gestures, like that of language, is specific to the culture in which they occur.

Time concept. Every culture has traditional ways of measuring time: these, after language, comprise one of the earliest things learned. Whether the individual is ahead of time, on time, or running behind generally relates to the importance attached to this concept..

Space concept. One aspect of the space concept concerns the place of our birth and childhood and the location of our established home. Cultural patterns tend to respect and encourage this tie between self and land. Another such aspect is the distance, small or great, between persons in friendly dialogue. This distance, specific to a given culture, is learned without awareness when very young.

Bonding. Ties that bind a person to her family and to her many kinds of mates — class-, team-, room-, soul-, and other — to religion, to political party, to the homeland. All these are found at the very core of culture. Bonding begins at birth and continues throughout life.

Learning. Learning may be formal or informal. Although to a great extent artificial, formal learning is directly related to the refinement of culture into the high civilization we know and of which we are a part. Learning of both kinds enable the individual in the shortest possible time to understand, to become competent in, and to take her place in her culture.

Ethics. Knowledge of what is right and wrong in human conduct is not innate but is learned by each person in contact with the culture. Models for honesty, fair play, principles, and moral thought and practice surround them, with which they are expected to comply.

Values. Values imply alternatives, comparison and preference. Given a person's nature and his ability to symbolize, the options available to him seem to be innumerable. Values can be both positive and negative: cleanliness, freedom, education, or cruelty, and crime. Values are manifesting ideals, in customs, and in institutions: they underlie ethics and esthetics.

Box 8.4 - continued

Religion. Religion is always found at the base of social structure. Child begin their encounter with the divine and the supernatural very early in life. No matter how people's reactions to these may change and modify as they grow older, religion will continue to have a distinct effect upon their thoughts and actions.

Heros and myths. Typical of any culture are its unique heroes who are known to everyone. Typical also are its myths and traditional or legendary stories about supposed beings or events, dealing with the creation of the world or man.

Ownership. Ownership is of essence to the individual. To have what is one's own, whether it is an idea, or an emotion, a privilege or a thing, is of great importance to the self. Cultural patterns have a strong influence over the possession of rights and properties as well as of loyalties and beliefs.

Ceremony. Ceremonies have long been immensely popular with human beings — culture prescribes the manner in which they are to be performed. What the individual is to say, wear, and do tends to be fixed, whether at a wedding, graduation, funeral, religious service, or new year celebration.

Sources: Materials from www.omhrc.org & NCCC

assume it is needed only by institutions that are located in states having a greater proportion of people who are of color. Some rule out implementing cultural competence programs because administrators believe it will be too costly — for example, the need for purchasing educational videos and bringing in consultants. The Joint Commission on Accreditation of Health Care Organization (1999) offers the following suggestions to organizations that wish to improve their cultural competence.

* Ensure administrative and policy support because it is difficult to be a culturally competent practitioner in a system that does not support cultural competence with policy.

* Conduct a cultural audit to assess the staff's knowledge of your patients' needs, expectations, cultural beliefs, and practices.

* Look at the composition of your staff in order to build a diverse workforce.

* Make diversity an important part of your quality improvement efforts.

* Secure financial support for training and education.

* Forge relationships with communities and culturally competent vendors.

* Ensure high-quality interpreter and translation services.

Additional resources can be accessed at minimal costs from a number of agencies, many of which are included in the bibliographic resources identified throughout this

text. For example, both the National Center for Cultural Competence (www.dml.george-town.edu/depts/pediatrics/gucdc/cultural.html) and the Office of Minority Health Resource Center (800-444-6472) www.omhrc.gov have extensive educational materials available in print and on the Internet along with an established network of experts who can provide technical assistance upon request.

Commit to diversity

Many health care systems simply pay lip service to the concept. Some claim to be culturally competent but do not have appropriate procedures in place to address diversity. Put the organization's plans in writing to demonstrate to employees and clients a commitment to cultural competence. A written plan makes everyone aware of the vision, goals, approach, and rationale for the cultural-linguistic competence program within the organization. Evaluate existing vehicles for communication to determine if these are culturally and linguistically appropriate for clients in the market area — for instance, consent forms, educational materials, telephone system, and the decor of the facility as a whole. Involve representatives from targeted populations in the community to assess and ensure that a clear communication path exists for each group.

Getting started: Create awareness

Early on, assesses employees' level of understanding related to diversity and cultural competence among employees. Several assessment tools are included in Chapter 7 of this text. A pre-test enables planners to obtain baseline data on individuals, programs, and the organization as a whole. Likewise, the questions in these assessment tools are useful to create individual awareness, initiate institution-wide discussion, identify staff learning needs, establish program goals, delineate objectives, and define time frames for an organization's cultural-linguistic competence program. Subsequently, post-tests are useful to measure changes in cultural awareness among individuals and the organization as a whole, determine program outcomes, plan future educational programs, and develop interventions that meet the needs of diverse clients.

Sensitivity training

Implement sensitivity training that is reflective of real-life situations and cultural events in the community. Invite guest speakers who can talk about specific ethnic/cultural perspectives and how staff competency improved quality and patient outcomes. Descriptions of 'best practice models" along with the associated challenges in implementing these can provide real-world cultural-linguistic insights to program managers and staff. Role playing and case studies are other strategies to engage clinicians in discussions and encourage clinical application of the information. Box 8.4 identifies cultural parameters that should be taken into consideration when developing sensitivity training programs within an organization or at the department level. Box 8.5 lists characteristics of a culturally competent department, unit, or team that also can be used as objectives when developing such programs.

Box 8.5

Characteristics of a Culturally Competent Unit/Team

- Respect the diversity among themselves (team members)

- Learn from one another about ethnic/cultural similarities and differences

- Demonstrate capacity to work with one another to bring about creative solutions

- Exhibit cultural awareness/sensitivity to target audience/community

- Seek opportunities for experiences with(in) targeted community/audience

- Facilitate community involvement in designing, implementing, and evaluating programs/services

- Interpret accurately the results of community needs assessments, client feedback, outcome data, and patient satisfaction surveys

- Identify/use existing networks within targeted audience/community

Sources: Materials from www.omhrc.gov & NCCC

Involve and empower minorities

Include minorities in leadership roles in the cultural-linguistic competence program. Decisions often are made for minorities without their involvement, which results in lack of ownership in the program or intervention. Empower individuals of various ethnic (minority) backgrounds to assume leadership roles on advisory boards and task forces and when planning, implementing, and evaluating the organization's cultural-linguistic competence program.

Establish an advisory committee consisting of seven to nine members that reflect the demographic makeup of your community. This group can provide relevant cultural insights as well as practical advice to the management team. Individual members are a link to the community in general and a targeted population in particular. Establish criteria for the membership — for example, the informal leader of a particular subgroup, someone having expertise in the language, a representative of the predominant faith community and/or political party. Be clear about what is involved for someone serving on the committee, such as time commitment, responsibilities, remuneration, outcomes of the project, and what the individual is expected to contribute to the group (e.g., marketing, development of materials in another language). Schedule meetings at convenient times and locations. For more effective use of meeting time, send agendas and reading materials well in advance of each meeting. Provide feedback to the advisory committee as to how their advice was used — and if not, why not. Periodically, prepare written

Box 8.6

Multicultural Competency Assessment for Organizations*

    This tool expands on the Multicultural Competency Assessment for Prevention Service Providers Tool; both were developed by the Wisconsin HIV Prevention Community Planning Council in consultation with Nara Smith Cox, Ph.D., associate professor at the University of Wisconsin, Madison, Department of Professional Development and Applied Studies. This tool assesses perceptions of staff and clients about how well an organization provides multiculturally competent HIV prevention service for people with different backgrounds. It can serve to identify and discuss areas in which your organization is multiculturally competent and identify areas in which improvement can be made. **

Rate the organization's current level of multicultural competency on a scale from 1 (not at all) to 5 (extremely).

At an AGENCY level, this organization:

1.   Has a written mission or vision statement supporting multiculturalism throughout the organization.

        1   2   3   4   5

2.   Has a board that includes a significant number of members reflective of the population the agency serves and intends to serve.

        1   2   3   4   5

3.   Has policies to ensure that decision-making processes include the voices of less powerful staff members and minority opinions.

        1   2   3   4   5

4.   Has an institutionalized commitment to recruitment and retention of staff reflective of the populations the agency intends to serve.

        1   2   3   4   5

5.   Has a systematic and long-term commitment to educate board members, employees, and volunteers about multiculturalism.

        1   2   3   4   5

6.   Shows its commitment to the communities served by involving community members in the design and evaluation of services and programs

        1   2   3   4   5

At an ADMINISTRATIVE level, this organization:

7.   Has advisory boards, task forces, and committees that include a significant number of culturally diverse community members.

        1   2   3   4   5

8.   Implements policies requiring the following individuals to participate in multicultural training.

        Board members 1   2   3   4   5

        Staff   1   2   3   4   5

        Volunteers   1   2   3   4   5

9.   Has a staff reflecting multicultural diversity at all levels of the organization.

        1   2   3   4   5

10.   Uses position descriptions that identify expectations related to knowledge, sensitivity and skills to serve diverse populations.

        1   2   3   4   5

11.   Advertises position vacancies in diverse print, other media, and organizations reaching diverse populations.

        1   2   3   4   5

12.   Has personnel policies that respect cultural differences (e.g, leave time is flexible to accommodate difference in holidays or important community/family events)

        1   2   3   4   5

13.   Provides opportunities for board members, staff, and volunteers to engage in self and agency assessment.

        1   2   3   4   5

Box 8.6 - continued

At a SERVICE DELIVERY or DEPARTMENTAL level, this organization:

14. Uses an intentional process (e.g., , needs and strength assessment) to collect information about the local target population from a variety of sources.

    1   2   3   4   5

15. Collects information to assess diversity among clients and staff.

    1   2   3   4   5

16. Can adequately respond to needs of clients whose primary language is different from that of the majority population served by the organization (e.g., Spanish, Hmong, American Sign Language)

    1   2   3   4   5

17. Actively involves individuals reflecting relevant differences (as listed below) in planning and designing prevention programs. Ongoing feedback from diverse individuals is obtained throughout the implementation and evaluation stages.

Ethnicity	1	2	3	4	5
Gender	1	2	3	4	5
Sexual orientation	1	2	3	4	5
Age	1	2	3	4	5
HIV status	1	2	3	4	5
Other	1	2	3	4	5

18. Has developed service linkages and working relationships with other agencies serving the same population.

    1   2   3   4   5

19. Ensures that clients are provided information in their primary language (though video, publication, with services of a translator, or appropriate referral).

    1   2   3   4   5

20. Provides client-centered services, which means the client's confidentiality is strictly maintained and the client retains the right to accept and reject services and to include partners, family members and others in these services.

    1   2   3   4   5

AND/OR

21. Provides population- or group-centered prevention education to address the needs and strengths or program participants.

    1   2   3   4   5

22. Makes referrals to other agencies, as appropriate, and prepares clients for interactions with these agencies.

    1   2   3   4   5

23. Involves clients and members of the community served in evaluation of the prevention programs.

    1   2   3   4   5

24. Documents and acts upon grievances and affirmations, with particular attention to issues related to cultural differences.

    1   2   3   4   5

25. Evaluates the outcomes of programs to determine whether the target populations are being served and whether the programs are successful in changing behaviors and norms consistent with the WI HIV Prevention Plan and State priorities.

    1   2   3   4   5

CONCLUSIONS

1. What are the most significant ways in which this agency (or department) strives for multicultural competency?

2. What are the three most important indicators this agency (or department) should focus on to enhance its multicultural competency? For each of these three, what are the next steps that need to be taken?

* For more information about the assessment tools contact the Wisconsin HIV/AIDS Program community planning coordinator, (608) 267-6730.
** These items could be modified/adapted to fit another service/program or unit.

Box 8.7

Organizational Evaluation Tool for Cultural-Linguistic Competence Programs*

The following questions can be used by organizations in the the self-assessment/evaluation:

What is your organization's experience or track record of involvement with the community or communities served?

❏ Does your organization have a documented history of positive programmatic involvement with the population or community to be served?

❏ Do your organization's staff, board, and volunteers have a documented history of involvement with the target population or community to be served?

What types of cultural competency training have your staff attended and what special qualifications does your staff have to work with the ethnic/racial/cultural/linguistic populations in your community?

❏ Does your organization's staff have systematic, periodic and follow-up training in cultural sensitivity and in specific cultural patterns of the community serviced?

❏ Are staff identified who are prepared to train and translate community cultural patterns to other staff members?

❏ Are there clear, cultural objectives for staff and for staff development?

Can these objectives be demonstrated by a staff training plan that:

❏ Increases and/or maintains the cultural competency of staff members?

❏ Articulates (clearly) standards for cultural competency, including credibility in hiring practices, and calls for periodic evaluations and demonstration of the cultural and community-specific experience of staff members?

❏ Places emphasis on staffing the program with people who are familiar with, or who are themselves members of, the community to be served?

Community representation

❏ Is the community targeted to receive services a planned participant in all phases of program design?

❏ Is there an established mechanism to provide members of the target group with opportunities to influence and help shape the program's proposed activities and interventions?

❏ Is a community advisory council or board of directors of your organization (with legitimate and working agreements) with decision-making authority established to affect the course and direction of the proposed program?

❏ Are members of the consumer cultural groups represented on the advisory council and organizational board of directors?

Box 8.7 - continued

❏ Are the procedures for making contributions or changes to the policies and procedures of the project described and made known to all parties?

Language

❏ If your organization is providing services to a multilinguistic population, are there multilinguistic resources, including use of skilled bilingual and bicultural translators whenever a significant percentage of the target community is more comfortable with a language other than English?

❏ Are there printed and audiovisual materials sufficient for the proposed program?

❏ If translations from standard English to another language are to be used, is the translation done by individuals who know the nuances of the language as well as the formal structure?

❏ Are all translations carefully pretested with the audience?

Materials

❏ Are audiovisual materials, PSAs, training guides, print materials, and other materials to be used in the program culturally appropriate or will be made culturally consistent with the community to be served?

❏ Is pre-testing with the target audience and gatekeepers conducted to provide feedback from community representatives about the cultural appropriateness of the materials under development?

Evaluation

❏ Are program evaluation methods and instruments consistent with the cultural norms of the group or groups being served?

❏ Is there a rationale for the use of the evaluation instruments that are chosen, including a discussion of the validity of the instruments in terms of the culture of the specific group or groups targeted for interventions? If the instruments have been imported from another project using a different cultural group, is there adequate evaluation and/or revision of the instruments so that they are now demonstrably culturally specific to the target group(s)? Are the evaluators sensitized to the culture and familiar with the culture whenever possible and practical?

Implementation

❏ Are there objective evidence/indicators in the initial program application and project work plans that demonstrate understanding of the cultural aspects of the community that will contribute to the program's success? Does the program plan address how to recognize and avoid culturally related implementation pitfalls?

* Adapted from materials published by the National MultiCultural Institute http://www.nmci.org

progress reports. Seek the input of the committee when evaluating the process and outcomes of the program.

The change process

Change, especially at an organizational level, will encounter resistance of varying degrees along the way. For most people, even positive changes involve uncertainty, some turmoil, and usually loss. Human responses range from outright sabotage, to passive resistance, to partially adopting the change, to enthusiastically embracing it. A highly effective strategy to overcome resistance is educating staff in advance about the change. This can help them see the need for and the logic of the change. Education can occur through face-to-face discussions with staff members, volunteers, and managers; through formal and informal group presentations; and/or in administrative memos and newsletter articles.

Education and communication are particularly effective when resistance emanates from inadequate or inaccurate information. Having members of minority groups conduct "awareness training" before implementing a cultural-linguistic competence program could be useful to educate and motive staff to participate more fully in it. Involve individuals who are most resistant in designing and implementing the change. Encourage those individuals to provide constructive input that could make the program more effective. Another way to handle potential or real resistance to change is by being supportive. Acknowledge that developing cultural and ethnic sensitivity requires that one reconsider long-held beliefs. Discussing such beliefs with the person and listening can help defuse resistance that is based on uncertainty, fear, and losses. Readers are referred to management texts that focus on the "change theory" and strategies to effectively manage the "change process."

Plan ongoing evaluation of processes and outcomes

Periodically, an organization should conduct a self-assessment of its capacity to provide culturally and linguistically competent services. Below are examples of questions that should be asked and examined (as an outsider would) to evaluate how accessible an organization is to customers who are of a minority group.

- Does the program have clear, forceful policy statements about the commitment to inclusiveness? (There should be verbal and written statements from the director and board president that the full board endorses.)

- Does the staff and board membership reflect the ethnic and cultural mix of the community that is served? If not, what efforts have been made to recruit minority members? Do members of the staff or board have ties to any of the minority communities?

- Does the program actively communicate with the minority communities by:

  - Making personal calls on leaders in those communities?

  - Making presentations to minority organizations?

- • Placing articles and recruitment ads in minority newspapers and newsletters?

- • Inviting members of minority groups to provide training on their culture for volunteers and board members?

- Does the program conduct initial and ongoing training on cultural awareness for volunteers, staff, and board members?

- Is the program accessible and appealing to a broad range of potential volunteers?

- Is financial reimbursement provided for volunteers' expenses (e.g., mileage, long distance phone calls, child care, parking)?

- Are training sessions offered at a time that is convenient for people who cannot easily miss work?

- Are strategies in place to accommodate people who have language limitations?

- Is assistance provided to people with limited writing skills for writing reports?

- Is the facility that is used for training facility inviting to people of various cultures? Are offices and classrooms physically accessible to the handicapped?

- Review printed materials. Do these materials reflect a broad mix of people from various cultures? Is there "tokenism" or pandering to any particular group? People from culturally diverse backgrounds need to know that the messages are not addressed exclusively to them. Furthermore, whites need to know that the institution values the contribution of people of color — that they do belong.

- How are demographic data collected, maintained, and used in program planning and evaluation? At a minimum you should be collecting:

  - • Gender, age, and ethnic composition of clients served by the program.

  - • Demographic composition of the community.

  - • Gender, age, and ethnic composition of staff, volunteers, and board members.

- Box 8.6 is a tool titled "Multicultural Competency Assessment for Organizations," and Box 8.7 is a questionnaire titled "Organizational Evaluation Tool for Cultural-Linguistic Competence Programs." Both instruments are useful for implementing and evaluating organization-wide cultural and linguistic competence.

SUMMARY

Diversity is more than ethnicity and race. Diversity includes gender, sexual orientation, age/generation, socioeconomic/educational status, employment, spirituality/religious beliefs, regional views, physical capacity, and immigration status. Cultural-linguistical competence is inextricably tied to quality of care and is a crosscutting issue affecting all health care services. The extent to which interventions and services affirm and reflect these values determines the appropriateness, acceptability, and accessibility of primary health care services.

CHAPTER EIGHT

Discussion Questions

- Using epidemiologic reports from the Centers for Disease Control or the State Department of Health, identify the most prevalent health conditions in your catchment area that could be associated with racial or ethnic factors. Describe treatment protocols for these conditions. Propose strategies to integrate the ethno-cultural beliefs into clients' care plans.

- What demographic changes are projected for your service area, and how could they affect the manner in which you plan, deliver, and evaluate services?

- Undertake an assessment of your organization using the information in this chapter to appraise its degree of cultural and linguistical appropriateness of services for your clientele. What are your organizational strengths? What areas need refinement? What must be done/changed to become a culturally and linguistically competent provider?

- Using the data from the self appraisals and the guidelines provided by external accreditation organizations/agencies, develop a plan to increase your organization's level of cultural-linguistical competence. What must be done for your organization to become fully culturally and linguistically competent — in other words, to reflect the population that is served?

- Organize a "Cultural/Ethnic Team" within your organization. Ask them to develop ongoing employee sensitivity training and education programs and activities that address the changing cultural-linguistical learning needs within the organization.

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Cross Cultural Health
www.xculture.org

Community Health Status Indicators (CHSI)
Health data at the local level, peer county information (counties sharing characteristics of population, size, density, age distribution, and poverty); reports include data on population characteristics, measures of health, leading causes of death, measures of birth and death, vulnerable populations, environmental health, preventive services use, risk factors for premature death and access to health care. Available from Health Resources and Services Administration's (www.communityhealth.hrsa.gov)

Using the CHSI Report in Your Community
Includes uses for CHSI reports, such as health planning and assessment resources; supplements current activities of health agencies. Published by National Association of County and City Health Officials (NACCHO) (www.naccho.org)

Diversity: Rx
www.diversityrx.org

Division of Migrant and Community Health, BPHC, HRSA, DHHS
4350 East-West Highway, 7th Floor
Bethesda, MD 20814-4410
(301) 594-4300

EthnoMed
University of Washington
Harbor view Medical Center
www.hslib.washington.edu/clinical/ethnomed

Indiana University
Online library on transcultural and multicultural health
www.lib.ian.indiana.edu/transnurs.htm

Interpreters Services Program
University of Massachusetts Memorial Medical Center
55 Lake Ave. N.
Worcester, MA 01655
(508) 856-5793

National Center for Cultural Competence (NCCC)
Georgetown University - Child Development Center
3307 M St. N.W., Suite 401
Washington, DC 20007-3935
(800) 788-2066
http://gucdc.georgetown.edu

National Mental Health Association
Position paper on cultural competency
www.nmha.org

The National MultiCultural Institute
3000 Connecticut Ave. N.W., Suite 438
Washington, DC 20008-2556
(202) 483-0700
Fax: (202) 483-5233
www.nmci.org
Consulting, diversity training, skills-building; publications/resource materials include trainer manuals, books on cross-cultural mental health and videos; a professional association for diversity practitioners, and partnerships with government and private organizations.

National Rural Health Association
One West Armour Blvd, Suite 203
Kansas City, MO 64111-3140
(816) 756-3140
www.NRHArural.org

New York Task Force on Immigrant Health (NYTFIH)
www.med.nyu.edu/NYTFIH

New York University School of Medicine
Office of Minority Affairs and Student Services
Schwartz Lecture Hall, 550 First Ave.
New York, NY 10016
www.med.nyu.edu/som/minority.html

Portland State University
Research and Training Center on Family Support and Children's Mental Health
Box 751
Portland, OR 97205
www.pdx.edu

State University of New York
CultureMed: Institute of Technology Library
P.O. Box 3051
Utica, NY 13504
315-792-7250
www.sunyit.edu/library/culturedmed
information on refugees from Bosnia, Russia, Asia; transcultural nursing, medical inter-
preters

University of California @ San Francisco
Culture and Communication in Health Care: A Curriculum for Teaching Culturally
Appropriate Care to Health Professionals — 2nd ed.
References, lecture topics, materials for didactic and experiential learning, evaluation
methods.
http://futurehealth.ucsf.edu/cnetwork

University of Minnesota
Center for Cross Cultural Health
410 Church St., Suite W227
Minneapolis, MN 55455
(612) 624-0996
www.umn.edu/ccch

University of Miami
Online library with information on sociocultural diversity and health care links.
www.library.miami.edu/staff/lmc

University of North Carolina
Minority Health Project
Annotated bibs on various racial and ethnic populations.
www.minoity.unc.edu

University of Wisconsin School of Medicine
Center for the Study of Race and Ethnicity in Medicine
1224 Medical Sciences Center
1300 University Ave.
Madison, WI 53706
(608) 265-5996
www.wisc.edu.crem

EVALUATION AND RESEARCH: CULTURAL AND LINGUISTICAL CONSIDERATIONS

OVERVIEW

This, the final chapter in this rural minority resource text, focuses on research and evaluation activities relative to cultural and linguistical competence. Health-related data on racial and ethnic minorities are sparse, often conflicting, and nearly nonexistent for minorities in rural areas. Considering the information deficit and the pervasive minority health disparities, the National Rural Health Association (NRHA) published an issue paper on the topic, *The need for standardized data and information systems*. (Appendix B) That document, along with publications by the Office of Minority Health and the National Center for Cultural Competence (NCCC), is the source of most of the content to be presented in this chapter.

Rationale

The Department of Health and Human Services (DHHS) notes that serious gaps exist in its information systems and databases with respect to racial and ethnic data. Over the years, the DHHS has established working groups to document the problems, develop solutions, and prepare official reports on minority-related research and evaluation . According to a DHHS report titled *Minority Health Data* (http://aspe.os.dhhs.gov/datacncl/racerpt/execsumm.htm) serious gaps remain in racial and ethnic data. Although there has been some improvement in the collection and reporting of health-related data for the predominant racial minorities, that is not the case for many underrepresented subgroups. Moreover, it is difficult to produce reliable data when extrapolating from national data sets for smaller minority groups residing in small towns or remote geographic areas.

Needed: quantitative and qualitative approaches

Cultural, racial, ethnic, and social factors interact in complex ways to affect health behaviors and the health status of individuals, families, and communities. Interaction effects generally are reported as life expectancy, mortality, morbidity, or disease etiology. Quality of life measures usually are described as socioeconomic status, standard of liv-

ing, job satisfaction, lifestyle, or quality of housing. Data from both measurement approaches (epidemiologic data and quality of life measures) can provide a more holistic view of a group's health risks. Specifically, qualitative approaches offer the human perspective ("lived experience") to flesh out epidemiologic and quality of life indicators. Combined approaches yield a more comprehensive "snapshot" of health within a particular minority group. For instance, epidemiologic data and quality of life indicators (e.g., poverty level, education, gender, race, place of residence) provide "hard" data about the health of a community as a whole. Qualitative indicators could possibly lead to insights about a subgroup's (in the community) health status and health care-seeking behaviors, such as a religious sect that opposes immunizations for children, or seasonal farm workers among whom several new cases of HIV recently have been diagnosed, or for middle-aged African American women who are known to have a higher mortality rate from breast cancer.

Measuring consumer satisfaction

Surveys often are used by health care providers to obtain information about a community (catchment area) and clients. Cultural and linguistic perspective must be taken into consideration when designing a survey tool to measure patient satisfaction. Appropriateness and acceptability of services implies that providers and the rendered care are congruent with the ethno-cultural preferences of targeted consumers. Satisfaction and desirability goes beyond dietary practices, pastoral care preferences, and pain management. Cultural factors influence one's definition of health versus illness, self-care practices, care-seeking behaviors, and manner of interacting with a health care provider.

Traditional survey evaluation methods often are not culturally and linguistically sensitive. For instance, satisfaction surveys often are in the form of a lickert scale. Respondents are directed to rate satisfaction with the care they received as "satisfactory," "unsatisfactory," "acceptable," or "unacceptable." However, little attention may be given by developers of the survey as to whether the person can read the language. (See Chapter 2 on functional illiteracy.) With the graying of America, another concern is declining vision abilities. The font size on many survey instruments is not large enough to be read by a large number of adults. Then there is the issue of English being the second language for many people. They may not be able to read English (or their native language for that matter), much less understand what the rating scale on the satisfaction survey refers to. Essentially, data from many satisfaction surveys may not be valid or reliable. To reiterate, both qualitative and quantitative methods are needed. However, ongoing input is needed from the members of the ethno-cultural group when designing research and evaluation methods. Linguistical and cultural competence requires input from the community to ensure that the proper questions are asked in the correct manner (e.g., appropriate words, tone of voice, demeanor). Refer to Box 9.1 and the bibliographic resources at the end of this chapter for tips on preparing culturally and linguistically appropriate surveys.

Box 9.1

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Tips for Designing Culturally and Linguistically Appropriate Surveys

Tip #1   Before designing a survey, write down the study objectives and the specific facts, figures, and/or opinions to be included in the final report. This will help ensure that all of the relevant questions are asked.

Tip #2   Invite individuals from the targeted sample (advisory group) to participate in preparing the questions.

Tip #3   The shorter the survey, the better the response rate. Only ask for information that specifically meets the survey objectives.

Tip #4   The #1 rule for survey questions is that they are clearly stated. Help ensure this by using short questions with simple words. Use words that are appropriate for the targeted individuals receiving the survey. Consider the reading ability/literacy level your target audience. Seek consultation from the advisory group regarding the "wording details." Make all definitions, assumptions, and qualifiers explicit. For example, "Do you own an old house?" does not explicitly define what "old" refers to.

Tip #5   Keep it simple BUT make sure all of the questions are valid. Survey questions must ask for information that the respondent is capable of providing an informed response.

Tip #6   Avoid leading questions that suggest the answer or reveal the investigator's opinion. For example, "Why do world championship football players make good senators?" is not a valid question.

Tip #7   Rephrase multi-content questions into separate statements. For example, "Have you gained the ability to administer your insulin plan and prepare your diabetic meal plan?" should be at least two questions.

Tip #8   In sequencing survey questions, proceed from broad (general) questions to more specific (detail) items.

Tip #9   Ask demographic/classification questions at the end of the survey. Order items from the least to the most sensitive.

Tip #10   Include the title, sponsor, directions, and thank you comments on the survey.

Tip #11   As for the overall format, avoid a long, formal, and monotonous appearance of the survey.

Tip #12   Remember to consider the visual ability of your target audience. For example, the average senior citizen probably will need a larger font than a younger person.

Tip #13   Proofread the survey for grammatical, spelling, and content errors, as these can affect the credibility of the study and the investigators.

Tip #14   To ensure that the survey performs as the designers intended, (pilot) test the survey on five to 10 respondents before administering it to the target population.

Tip #15   When analyzing and interpreting the data, include members of the advisory group to present the cultural dimensions that may apply or to share relevant insights.

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Outcome and program evaluation

Program evaluation and outcome measures must reflect diversity and should be culturally and linguistically appropriate. This means that minorities must be involved in the planning, implementing, analyzing, and disseminating of research. In recent years there has been a dedicated effort by federal, state, philanthropic, and not-for-profit entities to allocate more resources to minority-related research and evaluation activities. In turn, the competition for the resources has dramatically increased. The Office of Minority Health's *Closing the Gap* (April/May 2001) included information related to: seeking external funds (e.g., grants), writing competitive grants, and evaluating programs. (www.omhrc.gov) The following information is adapted from the article "How to evaluate your program" (S.K. Bowie, pp. 7;10) and is useful when preparing a competitive proposal for limited resources.

How to Evaluate Your Program
S. K. Bowie

A planned, integrated approach to outcome evaluation is key to the success of small projects and large multi-site, multi-components alike. Outcome evaluation is the systematic method for collecting, analyzing and using information about a program — measures the extent to which a program or strategy is reaching its objective but does not measure inputs, process, or methods.

Program managers and line staff oftentimes assess their program's effectiveness on an informal basis. But if it is incorporated into the framework of a program, rather than added on as an afterthought, evaluation can be a valuable tool to help improve program efficiency and the quality of a program. Evaluations can help program managers and line staff assess the effectiveness of their program to:

- Measure the impact of the program on individuals, families, communities, and/ or the target population;

- Determine program performance;

- Enable staff to make changes to improve program effectiveness;

- Document success; and

- Build your organization's credibility.

Think of the evaluation as a team effort. Line staff are very aware of and involved in the day-to-day issues of the program. They can provide the insight necessary to assist in the development of clear, specific outcomes or program objectives upon which sound evaluation planning is built. In addition, line staff will be less likely to view evaluation as threatening if they are involved with every aspect of the program — from design and implementation to interpretation of findings.

Involving experienced, on-staff evaluators or outside consultants early in the proposal-writing process can provide you with important technical assistance; help

you develop and focus an evaluation plan; and offer a new perspective on program operations. Many proposals mention evaluation but do not explain the specifics, such as what will be conducted or what will be gained. When writing your grant proposal, consider placing money in the budget for evaluation costs.

All too often, grant proposals are vague. For example, the proposal may mention evaluation but fail to explain the specifics, such as what will be evaluated, how the evaluation will be conducted, or what will be gained from the evaluation. Another common mistake in writing grant proposals is budgeting money for evaluation costs with the intent of developing the evaluation procedure at a later date.

Hiring an outside evaluator to conduct an evaluation is an option, but it can be expensive. On the other hand, channeling staff resources into an evaluation that is not properly designed or correctly implemented can be costly as well. Perhaps you have sufficient staff resources to implement the evaluation but need the assistance of a consultant to help you with the technical aspects of the evaluation. Conduct a careful analysis of line staff time and costs versus the expenses associated with an outside consultant to help you determine who should be a part of your evaluation team and their roles in the process. Keep in mind, grant funds may be available to help support outside evaluation efforts. Consultation and technical assistance resources include:

- Other organizations that have used outside evaluators;

- Local colleges and universities;

- Evaluation divisions or program assessment offices of state or local agencies;

- Technical assistance programs provided by federal agencies;

- Research institutes and consulting firms;

- National advocacy groups, and local foundations;

- Professional associations; and

- The public library.

Here are four easy tips for evaluating:

- Do it right — first impressions are lasting impressions;

- Do it early and do it often — so that difficulties detected as a result of the evaluation can be corrected;

- Use the results — incorporate the strengths and weaknesses found in your evaluation to improve your program; and

- Share the results with others — program staff as well as interested parties within the appropriate community may benefit from your efforts.

Helpful publications

The Program Manager's Guide to Evaluation, published by the Administration on Children and Families, U.S. Department of Health and Human Services (www2.acf.dhhs.gov/programs/hsb/core/puborg.asp)

Evaluation: Maximizing your prevention efforts, by the National Minority AIDS Council (www.nmac.org.tech/tapub.htm)

Framework for program evaluation in public health, by the Centers for Disease Control, U.S. Department of Health and Human Services — available by calling the U.S. Government Printing Office at (202) 512-1800.

Box 9.2

Are Clinical Trials (Treatments) for You?

Questions every person should ask and have answered before participating in a clinical trial:

- What is the purpose of the research?
- What is it supposed to show?
- What kinds of tests and procedures will I undergo?
- What drugs or treatments will I receive? What are their purposes?
- What risks will here be for me if I participate?
- Will the study directly benefit me? Will it benefit others?
- What discomforts, if any, will I encounter?
- What is the total time involved?
- May I discuss this with family and friends?
- Is there any financial remuneration for participating?

Source: www.omhrc.gov

Biomedical investigations

Historically, minorities have been underrepresented in all phases of the biomedical research process — even more so than those living in rural areas. Racial minorities traditionally have been excluded both in planning and implementing biomedical and health-related research, including epidemiological, behavioral, and community-based research and clinical trials. Nor have minorities been included in adequate numbers to provide statistically valid estimates of health outcomes and differences, if they exist. Increased participation by and for racial minorities in all biomedical research is needed, especially those residing in rural areas. Greater inclusiveness requires developing and implementing processes to increase funding to programs designed for and by minority communities and researchers. Emphasis must be placed on working with the communities to find

out what they believe their problems are, then providing the necessary financial and technical support to solve those concerns.

The NRHA published a rural minority health issue paper related to this topic, "The Need for Responsive Rural Health Delivery Systems" (Appendix D). Box 9.2 includes questions that should be addressed by providers when inviting individuals to participate in biomedical clinical trials. Box 9.3 lists common cultural barriers that can infringe on implementing valid and/or reliable investigations. The NCCC also published a policy brief titled *Partnerships for a Cultural Competence Research Agenda: The Role of Primary Health Care Organizations*. While their emphasis is on primary health care organizations, research and evaluation transcend all specialty areas in the continuum of health care delivery systems and for this reason are included in this chapter.

Box 9.3

Cultural Barriers to Implementing Valid and Reliable Studies

Reasons a participant of a different culture may not provide valid or reliable data:

- Lack of trust about the process and the investigator(s).
- Unfamiliar with standardized questions, multiple response options, rating scales, or "skip to" item designations.
- Wary of researcher(s) misusing information. Not understanding/believing information will only be reported as group data (not reported at the individual level).
- Perceive research as a form of exploitation in which non-minority individuals reap the benefits. Not understanding/believing the importance and value to the community of the data being collected.
- Concern about being used as a "guinea pig" in research.
- Believe only minorities should study minority populations.
- Perceive some questions to be inappropriate. Not understanding/believing certain questions must be asked of all participants.
- Perceive direct questioning as an inappropriate means of questioning. Information may need to be gathered with other approaches and/or indirect questioning (e.g., conversation, storytelling).

Sources: materials from www.omhrc.org & NCCC

NCCC policy brief: Partnerships for a Cultural Competence Research Agenda: The Role of Primary Health Care Organizations (Summer 2000)

Tawara D. Goode and Sharonlyn Harrisone,
www.dml.georgetown.edu/gucdc/index.html

Culturally competent methodologies are essential to effectively address the history of mistrust of research. There is a strong history of mistrust of research within diverse communities, particularly communities of color and among other non-ethnic cultural groups. It is a well-documented fact that communities of disenfranchised persons tend to distrust researchers and other professionals (Sieber, 1992). Such beliefs and perceptions have roots in historical, and unfortunately current, experiences that members of culturally and ethnically diverse groups have encountered in this nation's health care delivery systems. Many of these individuals typically view research through a prism of victimization and fear. This mistrust is reinforced by widely publicized research, such as the Tuskegee study, which continues to have ramifications on how medical and health care research is viewed among segments of the African American population today (Stevens, 1995). Research will likely have greater validity and relevance for the groups studied if the projects or proposals are culturally based and reflect the cultural competence of the practitioner, researcher, or research team (Brandt, et al., 1999). Research will also prove more valuable if groups who are studied have an investment and are active participants in all aspects and phases of the research process.

Cultural competence is necessary to mitigate long-standing exclusionary research methodologies and ensure reciprocity within diverse communities. Some diverse communities are reluctant to participate because they have never seen any benefits from research and they have never had the results shared with them (Henderson , 1998). Diverse communities have historically been involved as research subjects, but rarely in a decision-making capacity as equal partners with researchers. Other reasons why racial, ethnic, and cultural groups have not benefited from participation include the following:

- Researchers tend not to solicit involvement from group and community members until after a research project has been funded;

- Research methodologies and protocols do not substantively address within group differences among individuals of diverse racial, ethnic, and cultural populations. Research rarely portrays inherent strengths and resiliency within their communities;

- Research typically depicts their group or community in a negative manner;

- Research outcomes have been used to foster concepts of racial superiority or defectiveness between groups;

- Research outcomes have had little results on improving health status within the community at large or for its members;

- Research outcomes have not been disseminated in a manner that is useful to their community or group; and

- Research projects rarely provide economic benefits in terms of employment and reciprocity within their communities.

The majority of the previously cited barriers can be mitigated when culturally competent research methodologies are used. "Cultural knowledge must inform the entire research process. Merely including a particular underserved population in the sample or targeting an underserved population does not make a study cross-cultural. Cultural competence must infuse and suffuse the entire research process of planning, theory development, instrumentation, analysis, and interpretation to ensure cross-cultural validity and reliability" (Brandt, 1999). The active involvement of individuals, groups, and communities to be studied is a highly valued and integral component to the process.

Culturally competent research is characterized by the inclusion of participatory action or advocacy-oriented methodologies. This type of research strengthens the effectiveness of professionals, organizations, and service systems by providing them with accurate information to improve the efficacy of their work, and empowers diverse communities by equipping them with the knowledge and skills to understand health care issues and intervene on their own behalf. Culturally competent research should also incorporate the value of reciprocity, which is demonstrated by benefits derived from the allocation of fiscal and other resources to individuals and diverse communities that are studied.

There is an urgent need for racial/ethnic health data reliable data from racially and ethnically diverse groups are essential for the development of knowledge, strength and risk factors identification, preventive and treatment interventions, health education and public health policy. A number of barriers impede the collection of such data. They include but are not limited to the following. There is an array of different beliefs about the definition of race and what race means within social, political and biological contexts (Goode, T.D., 2000).

Sampling methodologies in national health surveys usually include a small number of members from racially, ethnically and linguistically diverse groups. This type of survey sampling makes it very difficult to draw conclusions on disease epidemiology. Policies at the Federal, state and local levels have been disinclined to mandate and enforce the collection of racial and ethnic data in health an human service programs.

For example, advocates were unsuccessful in litigation against the Health Care Finance Administration, U.S. Department of Health and Human Services, to voluntarily change a form used for collecting information between Medicare or Medicaid patients and health care providers to include racial or ethnic data (Madison v. Shalala, 80 F.3d 6th Cir. 1996). Improvements in health policy development, services and interventions cannot be realized for diverse populations without the comprehensive data sets that describe unique issues impacting them. In absence of these data, the ability to effectively impact and measure progress toward the goal of eliminating health disparities will remain elusive.

There is a need for research that documents racial/ethnic variations in response to treatment. Researchers have discovered that the use of standard con-

cepts, theories, instruments and procedures are often inappropriate for culturally diverse groups (Caldwell, et al, 1999). There is a dearth of literature and empirical studies that:

- address the methodological challenges of conducting research for diverse populations;

- document variations within racial and ethnic groups and between groups; and

- delineate differences among racial and ethnic groups in response to health education and other interventions.

For example, a recent literature review focusing on two areas of health disparity revealed the following: Although African American dialysis patients receive lower does of hemodialysis than their white counterparts, their survival when receiving dialysis treatment is better than for whites (Owens, et al., 1998). As a group, Asian and Pacific Islander Americans exhibit the highest mortality rates for selected cancer sites (female breast, lung, liver and stomach). Research indicates that there are numerous challenges to the provision of cancer prevention and control activities targeted at Asian and Pacific Islander Americans due to the influence of culture, acculturation, English and native language tobacco related media (Chen, 1998). Studies suggest that Asian and Pacific Islander Americans respond better to intervention and education strategies that feature peer interactions with lay Asian Americans of corresponding ethnic backgrounds; and consider cultural and linguistic factors. It is imperative that a research agenda recognize the importance of these critical areas and which add to the base of knowledge necessary to achieve the goal of eliminating health disparity among racial and ethnic groups.

There is a need for research that validates the efficacy of culturally and linguistically competent approaches to health care delivery. The current literature emphasizes the role of practitioners in the provision of culturally and linguistically competent health care, yet contributions that focus on research and policy development trail far behind. For example, while research has focused broadly on similarities and differences between racial and ethnic groups, there is little emphasis on validating approaches to health care delivery and health education that incorporate culturally and linguistically competent principles and practices. These studies must simultaneously address efficacy and the cost benefits of cultural and linguistic competence in health care, an area also underrepresented in the current literature. Primary care research can play a critical role in this area.

Formation of community-based coalitions for research partnerships is a viable strategy for developing a culturally competent research agenda. Cultural competence involves working in conjunction with natural, informal, support and helping networks within culturally diverse communities (e.g., neighborhood, civic and advocacy associations, local/neighborhood merchants and alliance groups, ethnic, social, religious and faith-based organizations, spiritual leaders and healers, ethnic and public interest media) (Cross, et al., 1989). Sustainability of these partnerships

will be ensured by primary health care organizational policies that support communities as an integral part of collaborative research efforts.

Participatory action research is a powerful approach for achieving cultural competence in research methodologies. Participatory action models promote partnerships between disparate stakeholders, builds capacity within communities, and ultimately strengthens community-based and other organizations working to improve health conditions in diverse communities. This model allows researchers to learn about the strengths, needs, and circumstances impacting those they seek to assist, and offers opportunities for the community to learn about the uses, requirements, limitations, and benefits of research. When program participants are involved in the generation and use of knowledge this enables different groups of people to act collectively based on informed decisions (Selener, 1990). A major benefit of this research model is a coalition of stakeholders informed and prepared to effect and sustain change in an effort to improve health care. Cultural competence at the organizational and individual levels is an ongoing developmental process.

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Advocating for a more inclusive research paradigm

Eliminating minority health disparities cannot accomplish in isolation. (Chapter 1) Since many of the determinants of well-being span the boundaries of health care and medicine, eliminating health disparities mandates new and non-traditional partnerships across diverse community sectors. Urgently needed are new protocols, approaches, and interventions that are grounded in research. A new research agenda must be developed

Box 9.4

Checklist to Facilitate the Development of Policies, Structures, and Partnerships that Support a Culturally Competent Research Agenda in Primary Health Care

While many health care organizations have structures and policies that govern their participation in research, few mandate the incorporation of culturally competent and participatory action designs. This checklist is designed to assist primary health care organizations to develop policies, structures, and practices that support partnerships to achieve a culturally competent research agenda.*

If the primary health care organization/program conducts or participates in research, does it have:

❏ a policy that requires research initiatives to use culturally competent and participatory action methodologies that include the active involvement of consumers/key stakeholders in all aspects of research process (e.g., designing, sampling, instrumentation, data collection and analysis, and dissemination)?

❏ a policy that delineates ethical considerations for conducting or participating in research initiatives?

❏ organizational structures and resources to participate in and/or convene coalitions concerned with the broad range of health, social, and environmental issues impacting racially, ethnically, and culturally diverse populations?

❏ a policy and structures to meet with members of diverse communities and advocates to determine priority health issues and needs as a basis to develop collaborative research initiatives?

❏ a policy, structures and procedures to systematically collect, maintain, and analyze health data specific to the racial, ethnic, and cultural groups served?

❏ a policy and practices that support personnel to participate on review boards within universities, colleges, and other organizations engaged in primary health care research?

❏ a policy, procedures, and practices that support reciprocity within a given community that partners in research initiatives (e.g., economic benefits, employment and other resources)?

❏ a policy, structures and resources to pursue grants/contracts or collaborate with other organizations to conduct research initiatives concerned with eliminating health disparities?

❏ personnel or employ consultants with expertise in conducting research that uses culturally competent and participatory action methodologies?

❏ resources, policies, and practices to provide information to consumers and communities about the benefits of participating or collaborating in research initiatives?

❏ policies and structures to help bridge the gap between current research as it impacts racially, ethnically, and culturally diverse groups and clinical practice including:

❏ personnel who periodically survey research studies and emerging bodies of evidence?

❏ a mechanism to examine research findings and their implications for policy development, clinical protocols, and health education?

❏ policy, structures, and practices to conduct health education for consumers on research findings that impact them and the communities in which they live?

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Developed by Tawara D. Goode and Sharonlyn Harrisone, Summer 2000.
Eliminating Health Disparity: A Mandate for a New Research Agenda
www.dml.georgetown.edu/gucdc/index.html

in collaboration with racial and ethnic minorities and must address fundamental changes in how investigations are designed, conducted, and disseminated to reflect diverse perspectives. Significant barriers hinder establishing and implementing a new research agenda coupled with increasingly diverse communities and the broad range of organizations and programs across the health care continuum. Some minority communities have not equitably benefited from their participation in research. Differing social, cultural, religious, and spiritual beliefs may deter certain individuals from participating in research. Likewise, new arrivals to this country (immigrants; refugees; documented and undocumented workers) may not be accustomed to or willing to participate in studies conducted by American researchers.

There also are barriers that investigators must overcome to carry out minority-focused research. For example, faculty in institutions of higher education generally do not use or teach investigative methodologies that are based on culturally competent and participatory action. (Appendix C) Funders of research, too, have been slow to require evidence of cultural linguistic competence, participatory action approaches, and advocacy-oriented activities in the grants and contracts they support. Additionally, peer reviewers for grant proposal and contract officers often do not receive the necessary training to enhance their knowledge in this area. Box 9.4 presents a checklist that was developed by the National Center on Cultural Competency that can be used for the development policies, structures, and partnerships that support a culturally competent research agenda in primary health care. While the emphasis of the tool is on primary health care organizations, the checklist lends itself to specialty areas in both acute and community-based health care facilities. (*Eliminating Health Disparity: A Mandate for a New Research Agenda* www.dml.georgetown.edu/gucdc/index.html.)

SUMMARY

The chapter focused on research and evaluation relative to cultural and linguistic competence. The discussion related to designing methodologies and creating a research agenda that reflects diversity. Publications from the Office of Minority Health, The National Center for Cultural Competence, and the National Rural Health Association were included that can be useful to implement culturally and linguistically competent investigations and evaluations.

CHAPTER NINE

Discussion Questions

- What does "cultural and linguistical competence" refer to relative to research, outcome measurement, and program evaluation? Provide examples and/or anecdotal information to illustrate your comments.

- Obtain surveys used within your facility — e.g., patient/client satisfaction, needs appraisal, community assessment. Select at least one and critique it to determine if it is linguistically and culturally appropriate for various (diverse) consumer groups in the catchment area. What are the strengths of the survey tool? What needs to be modified? Are different modifications needed for other groups? How has the targeted community been involved in implementing the survey? If it has not been involved, suggest strategies for involving the community in designing the tool, collecting and analyzing the data, and disseminating the findings. Do you believe the data are valid and reliable? Explain your answers.

- Select a program or service with in your facility. Review the program's evaluation procedures. Is there a formal evaluation plan? If so, describe it. What are the strengths of the evaluation plan? What should be modified? How has the targeted community been involved in the implementing the plan and/or measuring the outcomes?

- Describe biomedical investigations that are occurring within your community or health care facility. Describe how "diversity inclusiveness" is ensured in the investigations. Explain your response.

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EDUCATIONAL SUPPORT

American Indian College Fund National Headquarters
8333 Greenwood Blvd.
Denver, CO 80221
(303) 426-8900
www.collegefund.org

Hispanic Scholarship Fund
1 Sansome St., Suite 1000
San Francisco, CA 94104
(877) 473-4636
www.hsf net

National Health Service Corps Scholarship Program
4350 East-West Highway, 10th Floor
Bethesda, MD 20814
(800) 221-9393
www.bphc.hrsa.gov/nhsc

National Institutes of Health (NIH) -Office of Education
Building 2, Room 2E06
2 Center Drive MSC 0240
Bethesda, MD 20892-0240
(301) 496-2427
www.training.nih.gov

National Institutes of Health - Undergraduate Scholarship Program
2 Center Drive, MSC 0230
Bethesda, MD 20892-0230
(800) 528-7689
http://ugsp.info.nih.gov

Sallie Mae Inc.
11600 Sallie Mae Drive
Reston, VA 20193
(800) 239-4269

General information
Target Stores
Target All Around Scholarship
(800) 537-4180
www.target.com

United Negro College Fund
8260 Willow Oaks Corporate Drive
Fairfax, VA 22031
(703) 205-3400
http://www.uncf org

FEDERAL RESEARCH-RELATED ENTITIES

Agency for Healthcare Research and Quality
www.ahcpr.gov

Bureau of Primary Health Care
www.bphc.hrsa.gov

National Center for Cultural Competence
www.dml.georgetown.edu/gucdc/index.html

National Institutes of Health
www.nih.gov/grants

North American Primary Care Research Group
www.views.vc.edu/views/fap/napcrg98

Office of Minority Health Resource Center
www.omhrc.gov

The Cross Cultural Health Care Program
www.xculture.org

The National Association of Community Health Centers Inc.
www.nachc.com

The Federal Commons
Internet gateway to government-wide grant programs and funding opportunities sponsored by the National Institutes of Health, General Services Administration, National Science Foundation, Office of Naval Research and the U.S. Department of Transportation; www.cfda.gov/federalcommons/index.html

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Superintendent of Documents
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Pittsburgh, PA 15250-7954
(202) 512-1800
www.cfda.gov

Federal Register
Superintendent of Documents
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Pittsburgh, PA 15250-7954
(202) 512-1800
www.access.gpo.gov/nara

FEDIX
Federal agencies that offer grant information to educational and research organizations.
http://content.sciencewise.com/fedix

GRANTSNET
Office of Grants Management
(202) 690-6377
www.hhs.gov/grantsnet

HEALTHFINDER
www.healthfinder.gov

Minority ON-line Information Service (MOLIS)
http://content.sciencewise.com.molis

NIH Guide for Grants and Contracts Grants Information
Division of Extramural Outreach and Information Resources
Office of Extramural Research National Institutes of Health
(301) 435-0714
http://grants.nih.gov/grants/guide/ index.html

U.S. Department of Education
400 Maryland Ave. S.W
Washington, DC 20202
(800) 872-53276
www.ed.gov

What's new at HHS Listserv
www.hhs.gov.watsnew

Who's Who in Federal Grant Management
www.hhs.gov/grantsnet/whoswho.htm

MINORITY PHILANTHROPIC ENTITIES

Asian American Pacific Islander Philanthropy (AAPIP)
225 Bush Street, Suite 580
San Francisco, CA 94104
(415) 273-2760
www.apip.org

Fast Nations Development Institute (FNDI)
11917 Main St.
The Stores Building
Fredericksburg, VA 22408
(540) 371-5615
www.firstnations.org

Hispanics in Philanthropy (HIP)
2606 Dwight Way
Berkeley, CA 94704
Fax: (510) 649-1692

The National Center for Black Philanthropy
1110 Vermont Ave., Suite 405
Washington, DC 20005
(202) 530-9770
www.ncfbp.org

A NATIONAL AGENDA FOR RURAL MINORITY HEALTH
AN ISSUE PAPER PREPARED BY THE NATIONAL RURAL HEALTH ASSOCIATION — MAY 1999

In partnership with President Clinton's Initiative on Race, which has already made a national commitment to eliminate racial and ethnic disparities in six areas of health status for racial and ethnic minority populations by the year 2010, the NRHA in 1997 developed A National Agenda for Rural Minority Health. The purpose of this agenda is to address access gaps and the growing disparities in health status indicators for rural minority populations. The agenda is organized and developed around three priority areas: information and data, health policy and practices, and health delivery systems.

The three priority areas are presented within the agenda as part of a strategic plan of action that includes objectives and implementation strategies. Also included is the process for identifying partners to participate in the agenda's formulation, implementation, and evaluation steps, all of which are a necessary part of a national policy or issue of focus. The agenda is intended to serve as a document that can be used in a prescriptive manner by state and local health and health-related agencies for setting priorities and community funding for major rural minority health initiatives. It includes specifically focused vision statements and implementation strategies for use by multigenerational, rural minority communities into the next millennium. In keeping with the President's Initiative on Race, which sets a goal of "One America in the 21st Century," the NRHA believes we must prepare to live as one nation in the coming new century, with equal health status outcomes and expectations.

The value of a national agenda for rural minority health

In 1993, a charge was given to the NRHA by the Rural Minority Health Advisory Committee to develop a dynamic document that could be implemented for the next five or more years — however long it takes to bring the changes to fruition. This process resulted in the following overarching values of a health care delivery system on which the agenda is based.

- *Community Based.* Accessible to the community being served by being within reach during times of need, the community-based health care system is equitably distributed and universally available in all areas.

- *Culturally and Linguistically Competent.* The culturally competent system is responsive in its staffing, health care delivery, and personal interactions with patient groups, using ways that are familiar and comfortable to them. It is also sensitive to cultural differences and modifies practices to incorporate those differences, integrating traditional and western medicine as appropriate. It is flexible, creative and resourceful in providing care within the constraints of limited health care resources and involves patients and families in the decision-making process.

- *Comprehensive.* The mix of health care modalities, services and personnel must be commensurate with identified needs, health status indicators and demographics of the community being served.

- *Creative.* New and different solutions will recognize the unique needs, capacities and strengths of different populations, even within the same rural minority group.

- *Community Involvement.* The development of policies and programs should involve the active participation of rural minority communities and their representatives. Inclusion of community members in the process is necessary to identify emerging needs and health care problems as well as to facilitate the incorporation of traditional and western practices.

- *Cost Effective.* Access must be affordable through the allocation of funding to pay for reasonable health care services. Further, it must be distributed in ways that are designed to overcome disparities to bring at-risk populations up to a level of health care and quality of life comparable to the population at large.

This value system serves as the framework on which the agenda's three priority areas are structured. These values also will serve to guide the final plan development and implementation process. Strategies that involve resources from sponsoring and funding agencies or interest groups, or administrative, technical and budgetary support to enact this agenda must incorporate these values as well. As we move forward into the 21st century, we must have clearly defined values and goals as well as commonly held ideals that will prepare our country to live as one nation.

The three priority areas of the agenda

The structures of A National Agenda for Rural Minority Health are linked to three priority areas. This paper summarizes these areas of the agenda.

Information and data

Currently there are sparse and inconsistent health-related data on rural minority populations. To reduce health disparities, there must be adequate data concerning the health status, health care patterns of utilization, health care financing and health out-

comes for all rural and ethnic minority populations. Action steps recommended to facilitate these needs follow.

- Rural minority communities will routinely participate in the planning of data collection in all aspects concerning health, illness and the health care system.

- Rural minority communities will actively participate in interpreting and using data to plan changes and make decisions concerning all health-related issues in their communities.

- Data collection systems will incorporate core data sets and employ uniform definitions for relevant terms to facilitate information sharing and comparisons among and across minority populations and non-minority populations as well.

- Data analysis and interpretation of findings will reflect sensitivity to the unique cultural attributes of the population on which data are being collected and used.

Health policy and practices

The goal is to achieve a system of health care that provides comprehensive health care services for multigenerational, rural minority populations. As part of the President's Initiative on Race, the elimination of health disparities has been formally acknowledged as a policy issue of top priority. The agenda recommends the following.

- Policies should be developed at the state, local and national levels that ensure access to comprehensive health services regardless of ability to pay or immigration status.

- Given the higher degree of uninsurance in both rural and minority populations, to improve the health status of these populations it is imperative that all people in America be covered by health insurance.

- All providers throughout the health care system must practice preventive measures and include wellness concepts by providing health education to all patients. There should be means to ensure adequate funding of health education and other enabling services.

- Health systems and professionals will focus on prevention and wellness concepts by advocating lifestyle modifications and regular physical checkups.

- Measurement of comprehensiveness of health services will be provided by monitoring access to essential services as well as the types of services that are affordable to rural minority populations and by evaluating the quality of care being provided.

Health delivery systems

It is necessary to view health care as a right, not a privilege. Primary health care delivery systems must be developed that not only eliminate health disparities in six areas of health status for racial and ethnic minority populations but also substantially improve the health status of these populations. To do so, health care services must be:

- linguistically and culturally appropriate for the community;

- based on the assessed needs of the community;

- responsive to the community's input;

- linked to other health and community systems;

- cost effective;

- accessible to all rural minority populations; and

- situated within an integrated network of health services and systems.

Summary

The NRHA will work to further develop and implement A National Agenda for Rural Minority Health. Due to the President's Initiative on Race and the national mandate to eliminate health disparities by 2010 in six areas of health among racial and ethnic minority populations, the NRHA believes that now and into the coming 21st century, the time is appropriate to move this agenda forward. Clearly, with such a mandate for change and a national policy issue acting as a guiding force for the nation, A National Agenda for Rural Minority Health that begins to address the question of "how" is an important component in meeting the goal of "One America in the 21st Century."

Addendum

In August 1998, the NRHA's Rural Minority Health Committee identified health professions as a fourth priority area to be addressed. To more effectively detail A National Agenda for Rural Minority Health, a series of four issue papers focusing on each of the four priority areas of the agenda will be written in the future. These papers are:

- information and data;

- health policy and practices;

- health delivery systems; and

- health professions.

A National Agenda for Rural Minority Health Series
The Need for Standardized Data and Information Systems
Issue paper prepared by the National Rural Health Association — April 2001

INTRODUCTION

In rural minority populations, unique patterns and occurrences of disease produce health needs that sometimes differ greatly from those of the general population. In order to determine the true picture of need among these at-risk groups, data are essential. Yet, currently, there exist sparse and inconsistent health-related data concerning rural minority populations. While there are a multitude of data being collected and analyzed nationwide, little pertains to rural minority populations. Thus, the results are not useful in terms of designing programs and initiatives for these populations. These limitations of data result in barriers that affect programs, services and efforts focused on health and quality of life issues. These barriers must be addressed collectively and individually as part of the initiative for data accuracy and completeness.

Strategies

In order to deal more effectively with data problems and offer solutions, the commonly shared limitations of data nationwide must be considered. In a review of the major databases, five common areas of need emerged concerning the limitations. The five areas of identification were:

- racial misclassification;

- undercounting;

- coding errors (universal to people of all races);

- inclusion of insufficient numbers of the racial group to formulate conclusions; and

- data collection in selected geographic regions that cannot be generalized to people in other areas.

In the review of materials concerning coding and minority populations, the single category of largest error was racial misclassification. Several published articles directly mentioned the use of the category "other" in data analysis methods and its adverse effect on developing an accurate picture of the true state of affairs in rural minority pop-

ulations. The problem of race directly affects data that have been collected in the past, data analysis, and future data needs. Researchers have grappled with problems associated with racial misclassification and all its implications for decades. They express concern, however, that among minority populations, there may be inaccurate reporting of race. All national databases use death certificates and birth records for racial categorization if race is previously unknown. Yet if the racial classification is wrong, there will forever be false data, resulting in erroneous conclusions and analysis.

Mortality and incidence rates are affected by inaccurate coding, due to inaccurate information being present in state records and passed on to national databases. The researcher, program planner or service organizations must be aware of these gaps and limitations when designing, implementing, funding and evaluating any health program or data issue relative to rural minority populations. The categories of race for the purpose of data are needed to assist in defining differences involving factors such as ancestry, racial, ethnic, tribal or cultural groups. Variances in lifestyle, diet and health behaviors contribute to the health differential experienced by racial and ethnic populations. Data to be usable must be reflective of the minority populations and their needs.

Another area of concern is the collapsing of data into primary categories. This combining of data from several small sets into one larger category, to facilitate analysis and management needs, frequently results in lost or hidden data in regard to minority populations. Errors such as these often result in poor coding, or worse yet, coding errors themselves. In turn, the findings may not be representative of the population in question, leading to errors in inference. Racial misclassification on vital records, in disease registries, and census data, which are usually used for denominators in calculating rates, relies on self-identification of race. Vital records are often entered by a third party (funeral director/health care practitioner) based on appearance or surname.

This is a major barrier to understanding and developing a true picture of the morbidity/mortality of underserved rural minority populations. The appropriate linkage of numerators and denominators in calculating health statistics is essential. Because denominator data for health statistics come from the Census Bureau, which relies on racial self-reporting, unrealistically low estimates of morbidity and mortality among rural minority populations in particular have occurred. At the same time, numerator data from vital records and disease registries is used and includes the same erroneous data counts based on racial misclassification.

Rural minority populations are at a disadvantage in today's databases, due to coding errors, among other factors. Steps to correct this, such as implementation of commonly shared data linkages, will help overcome lack of statistical insignificance and undercounting. Coding using a universal system is essential today as technology moves more into computer based study procedures to facilitate data access, management and analysis.

The lack of standardized definitions upon which to base coding decisions is another area of concern. Lack of common definitions for use in broader database linkage and merging of databases are seen as a major handicap and are significant barriers to

research. Comparison and combination of data from databases using differing definitions or coding is prevented, limiting sample size. The sample sizes for racial and ethnic populations in most databases are not sufficient to reveal statistically significant differences among populations when those differences exist and do not allow analysis and inclusion due to low discriminatory power of the studies. Studies that focus on particular subgroups within racial and ethnic categories (e.g., tribal affiliations) have an even greater problem with insufficient statistical power. In the past, a common solution to this problem was to collapse all racial categories into three groupings: Caucasian, African American and "other." The result was and remains hidden important information about specific racial and ethnic populations. This not only obscured findings at the time, but prevents secondary analysis of the data in new studies or retroactive studies today.

"Undercount" refers to the difference between the number of persons counted in the census (or other programs) and the true population size. Most researchers are concerned about undercount and whether the undercount is concentrated in certain groups or areas, leading to non-random biases in the data and to misinterpretation of results. Bias also is introduced when the methods of the study lead to an undercount. A telephone study or survey is an example in which the homeless, precariously housed individuals, those too poor to afford telephones or areas that do not have telephone service available (true in several isolated reservations) are all automatically undercounted. The undercounting problem is so widespread and of such duration that the U.S. Census Bureau does not question if it occurs but rather measures the size of the undercount. Clearly, the undercount in national level data sets must be addressed before any type of significant data analysis or even data collection can be undertaken. To develop data about rural minority populations, a statistically significant number to allow formulation of conclusions must be a prerequisite of all research efforts.

Areas such as these highlight the critical need for inclusion of rural minority populations not only in national databases but in the process of data collection itself. National data that is accurate and represents the true state of affairs is essential. The diversity of health needs and health status at the community level or even at the geographic area level is masked because of these recorded errors in databases as a matter of routine. Considering how culturally and geographically diverse persons are in the United States, this information is essential for the service organizations and programs as well as the community itself, to use in health care planning and needs assessment. The status of the community and the communities needs cannot be determined without it. The system of federal funding is set up from a resource allocation standpoint, which uses people served and priority areas of needs, which are based on patterns and trends of utilization, morbidity and mortality, all derived from national databases.

Lack of rural minority population-specific data confounds decisions concerning these areas and prevents the necessary targeting of services to address specific health problems among high-risk groups within these populations. Inconsistencies in data can have important implications for health planning and resource allocation, which affects generations of people, not just the present group members.

Actions and implementation steps

The National Rural Health Association recognizes that these problems have a significant impact on the quality of U.S. data concerning rural minority populations. Measurement error strongly affects all phases of the data process and its usefulness. There are reliability problems with the assessment of race that suggest there is an acute problem of undercounting racial and ethnic status for American Indians/Alaskan Natives, Asian Americans and Pacific Islanders, and Hispanics, among others. Research and needs assessment of minority communities must be conducted using more accurate methods. In an effort to address these needs and issues, steps must be taken to effectively ensure adequate data concerning the health status, health care utilization patterns, health care financing and health outcomes for all rural minority populations incorporating the "umbrella" of the recognized five common areas of need previously listed.

Recommendations

In order to begin addressing these barriers the following recommendations are made.

Availability

Data and information are not available for all health issues of concern to all rural minority communities. Currently, systems are not set up to address the issues presented in this statement. To do so, there must be an understanding of what systems exist, what they do, and how they are set up to work. To do this, there should be a focus on two axes: (1) available information and data (have), and (2) unavailable information and data (do not have). The definitions, even the studies themselves, should be determined by who is being studied, the purpose of the study, and why the research is being conducted. The data that already exist need review and additional needs and gaps within these data needs to be identified. Data fitting the individual needs to be developed by asking the right questions and finding the best way to accomplish what needs to be done.

Common terminology

Definitions used in data collection should use common terms that truly reflect the rural minority populations and their needs. In order to facilitate this, we recognize data collection of race and ethnicity issues are hindered by problems of definitions and measurements. Developments that would facilitate the linkage of existing databases include:

- standardization of definitions;

- accepted medical terminology for patient care data coding and storage;

- sharing of data, as appropriate within confidentiality limits; and

- greater coordination of federal, state and private policies on data access.

Local data

The need for more local level data is recognized. The development and review of mechanisms to allow this to occur and to facilitate the process of information and data collection and utilization are necessary. To allow data to be disaggregated from the national level down through all data collection levels would require the following steps:

- the use of technology to the fullest possible extent in the collection, analysis and dissemination process;

- the delivery of findings using technological methods, such as distance learning, computer networking, teleconferencing and other technology-driven avenues; and

- the realization that Third World conditions (e.g., illiteracy, lack of technical resources and computers, etc.) will hamper the technological delivery of findings, and that other avenues, such as direct teaching and newsletters, can and should be part of the delivery and dissemination process as well.

Community "ownership"

Community "ownership" of all data is a cornerstone of the data process itself. Cultural ways and the reality of rural community life must be concerns of researchers and be factored into all research efforts and initiatives. Cultural competency, cultural appropriateness and cultural sensitivity are needs that are recognized and are most fully met when the "community" is a full partner in each step of the data process. In order to encourage community partnerships, the following steps are urged:

- Involve and train community members to serve as point persons in the data collection process. Community/tribal persons are much more likely to be successful in access and data collection than an outside researcher;

- Clarify the role of rural minorities by developing strategies to ensure community involvement in data collection processes;

- Define research needs in conjunction with rural minorities by increasing the participation of minorities (individuals, institutions and communities) in designing, conducting, analyzing and interpreting research studies;

- Educate and empower communities to use research data in policy and program development;

- Establish protocols for effectively approaching and involving minority communities in these research studies;

- Provide computer technology and training to facilitate the use of data and information in further involving rural minority communities in making decisions about their health care; and

- Consider the time-sensitive nature of minority data by shortening the time frame between data gathering and data reporting as a strategy for empowering a minority community.

Summary

The National Rural Health Association favors adoption of the strategies listed above in data gathering on rural minority populations. Five areas of common needs and four areas of focused efforts are urged in this issue paper. Their purpose is to achieve and maintain a quality of life within the multigenerational rural minority populations from the individual, community and local level upward to the national level and to eliminate all health disparities within these at-risk persons and groups and to advocate a healthy lifestyle with prevention as well as treatment as an accepted norm.

A National Agenda for Rural Minority Health Series
Recruitment and Training of Health Professionals
Issue paper prepared by the National Rural Health Association — April 2001

Introduction

Approximately 61.7 million (24.8%) of U.S. residents live in rural settings (1990 Census). Rural ethnic minorities, including African American, Asian American, Native American, Hispanic and others, comprise about 11.2% of Americans or 6.9 million people. Rural populations frequently have difficulty accessing adequate health care (Rabinowitz et al., 1999). The lack of adequate numbers of practitioners and in particular, ethnic minority practitioners in rural areas, is an obvious problem. Kamoromy et al. (1996) found that communities with high proportions of African-American and Hispanic residents were four times as likely as others to have a shortage of physicians, regardless of community income.

Conventional wisdom says factors (in addition to lack of practitioners) playing a role in making access more difficult for minorities include linguistic and cultural barriers, such as distrust of health care providers, chilly reception by health care providers, comfort with home remedies, and traditional care methods and discomfort with conventional Western care. The 1990 census shows linguistic isolation among 25.1% of Asian Americans, 23.8% of Hispanics, 4.5% of Pacific Islanders, 4% of Native American/Alaska Natives and 0.9% of African Americans. Practitioners who understand the language and tradition of their patients and communities may offer a more complete and effective kind of health care (Thomson and Denk, 1999).

Health care providers from underserved communities are more likely than other practitioners to provide care to underserved patient populations (Pew, 1998). Ethnic minorities (with the exception of some Asian ethnicities) are woefully underrepresented in the ranks of health care professionals. In 1990 census data, African Americans comprise 12.1% of the population and only 3.7% of the physicians; Native Americans comprise 0.8% of the total population and 0.2% of the physicians and Hispanics comprise 9% of the population, yet only 4.9% of physicians. Pharmacy reflects similar underrepresentation; in 1990 census data, African Americans comprise only 3.7% of the pharmacists, Native Americans comprise 0.2% of pharmacists and Hispanics comprise 3.1% of pharmacists. African Americans are slightly better represented among physician assistants and registered nurses, though they are underrepresented in these vocations as well. Of

1.9 million registered nurses in the United States in 1990, about 8.9% were African American, while 8.7% of all physician assistants were African American.

When looking at the Asian-American and Pacific Islander populations in terms of health care provision and cultural and linguistic match, little data exists. The ethnic diversity of these populations is vast and often not understood. The often-used aggregate category of "Asian American and Pacific Islanders" reflects more than 60 distinct ethnicities with more than 100 distinct languages and dialects. In addition, the diversity includes indigenous populations such as Native Hawaiians and other Pacific Islanders, populations with multiple generations in the United States such as Chinese and Japanese Americans, and populations who were essentially unknown in the United States until the 1970s such as Hmong and Mien. Complicating matters even more, many of the these populations have a history of being antagonistic toward one another. Finally, cultural traditions and language often are lost between the first generation immigrant and the second generation American-born; therefore, ethnic identity is not a proxy to cultural and linguistic competency.

Therefore, to say that "Asian Americans and Pacific Islanders are overrepresented" is an over simplification that does not recognize the great diversity within this federally recognized category. (Beginning in 2000, the Office of Management and Budget separated "Asian Americans" from "Native Hawaiians and other Pacific Islanders.") Demographically, especially related to health status, Native Hawaiians and other Pacific Islanders are more similar to Native Americans than to Asian Americans. Numerically, over 98% of the Asian American/Pacific Islanders category is Asian and less than 2% is Pacific Islander. The implications of this are tremendous. Asian Americans have, on average, greater health status indicators than even those of Caucasians in America; however, the overwhelming proportion of Asians mask the poor health status of Pacific Islanders.

While there may be an overrepresentation of Asian-American graduates in the health professions, one must look at those who are providing direct primary care as opposed to specialist or academic medicine, or if they are specifically serving their ethnic community or the community at large. It is not enough to simply match ethnic backgrounds. Studies have shown that the people most likely to locate and provide health care among minority populations are those who originate from these areas and those that are trained in these areas (Rosenblatt et al., 1992). A recent study of U.S. medical graduates shows racial and ethnic minority physicians are, in general, more willing to provide care to poor patients who find themselves with no insurance or public insurance such as Medicaid (Thermond and Cregler, 1993). However, the issues surrounding the lack of representation of these populations in health careers are often similar, and the barriers preventing successful underrepresented students from pursuing health careers are many. These barriers include:

- lack of adequate pre-college preparation for higher education during grade school and high school;

- lack of financial support toward higher education;

- lack of parental and peer support toward these goals;

- lack of health care role models both locally and in mass media, who rarely portray minorities as health professionals;

- lack of awareness of opportunities for careers;

- health professions schools admissions standards that select against these populations;

- health professions schools admissions committees that inadvertently select against these populations; and

- institutional and environmental disincentives (Pew, 1998).

Strategies/action steps
Preparing underrepresented students for college

Evidence shows that efforts to overcome barriers toward higher education and health career majors can be effective in the practices of elementary and high school preparatory programming for underrepresented students. The Health Resources and Services Administration has provided funds to numerous institutions of higher education for over 25 years to provide pre-college educational enrichment and social support for disadvantaged students interested in health careers. Through these and other means, colleges and universities have shown some success. For example, the University of Louisville has increased its number of underrepresented minority students enrolled at the school to almost 10%, up 2-3% from before 1993, through many years of developing and implementing a continuum of preparation and retention programs at the elementary and secondary education levels (Crump et al., 1999).

The Louisiana State University School of Medicine has a summer science program for Louisiana high school students from underrepresented minorities. An estimated 432 of 665 students have chosen education paths in medicine, another health profession or science since 1985 (Heml et al., 1999). In the Health Sciences and Technology Academy at West Virginia University, 98 students from West Virginia were given social support and academic enrichment for four years prior to college. Forty-nine percent of the students were African American or biracial, while 51% were rural, disadvantaged Appalachian whites. Ninety-six percent of these students are currently in college, while only 51% of their peers went to college. Seventy-seven percent are majoring in pre-health career majors with average grades fully one-half a point higher than their peers majoring in the same fields who were not in the program (McKendall, 2000). Similar results are shown for Hawaiian Natives (Little et al., 1999), Hispanics, and Asians/Pacific Islanders (Palacio-Cayetano et al., 1999). These results show that just a little special attention from kindergarten through 12th grade has a tremendous impact.

Preparing underrepresented students for professional school

Efforts to prepare ethnic minority students for professional school are effective in the practices of the historically black colleges and universities. Xavier University alone produces 7% of the African-American applicants to medical schools. Undergraduate programs and post-baccalaureate programs in majority institutions scattered across the nation provide minorities and other underrepresented youth academic enrichment and social support toward health careers beginning the summer before coming to college and following them through professional school.

The University of Virginia Medical Academic Advancement Program for minority and disadvantaged students has been successful in increasing the number of underrepresented minority students matriculating into and continuing in medical education (Fang et al., 1999). This program and others illustrate successful approaches at the pre-matriculation level (Williams, 1999). Southern Illinois MEDPREP is a successful post-baccalaureate program. This program establishes high expectations for student progress, designs individual curricula, offers extensive academic and personal counseling, has its own teaching faculty and operates in a specially equipped designated facility. Since 1972, MEDPREP has served about 900 minority and disadvantaged students. By 1998 over 500 MEDPREP students had been accepted into medical or other health professions schools, and 86% of them had graduated or were scheduled to graduate. These students make two to nearly six times greater improvement in MCAT retakes than non-MEDPREP students (McGlinn et al., 1999).

The pipeline for students graduating from high school through undergraduate training and through professional school education is long and demanding. Consequently, a number of reinforcements and supports are needed through this multi-year pipeline. Even maintaining a database from high school through graduate school or medical residency is an enormous challenge but necessary to accurately reflect results of programs.

Preparing practitioners to serve the underserved

A concerted effort needs to be made to understand the underserved populations to best prepare practitioners to serve them. Cultural and linguistic appropriateness of the traditional training needs to be assessed and adapted to promote more appropriate interactions with underserved people. The usage and potential conflicts in usage of alternative medicine by these populations need to be assessed and addressed in training practitioners to promote more appropriate interfacing of traditional and alternative medical practice. Training of practitioners needs to incorporate culturally sensitive mental health promotion, general health promotion and disease prevention. The nation needs to evaluate the current rural and minority health initiatives to identify gaps and determine needs.

Policy recommendations

The authors make the following recommendations:

- Promotion of financing and payment mechanisms for financially disadvantaged rural minority students — for example, tuition fee waivers.

- Promotion of the depiction of minorities as health professionals in the mass media.

- Promotion of the development of innovative career awareness programs in minority communities.

- Promotion of programming to focus on the recruitment and retention of rural ethnic minority students at the pre-college, college and professional school levels.

- Promotion of financial support for programs that produce positive results and grant opportunities to encourage more efforts in this arena.

- Promotion of professional school linkages with rural minority populations.

- Promotion of linkages with congressional African-American/Hispanic and rural health caucuses and other leaders in Congress who are sensitive to health disparities confronting ethnic/racial minorities that are especially compounded in rural settings.

- Promotion of creative admissions policies and procedures that do not inadvertently select against rural minority populations (i.e., adapt policies where MCAT requirements for admission are in line with MCAT scores of successful graduates from underrepresented populations).

- Provide opportunities for provisional admission based on performance.

- Promotion of residency program policies that encourage placements in rural, medically underserved areas.

- Promotion of state loan forgiveness programs for practitioners who serve rural underserved populations.

- Promotion of existing practitioners or those in training to reach out to minority youth in rural communities to assist them in becoming the next generation of health care practitioners working in rural America.

- Promotion of funding to health careers opportunity programs and Area Health Education Centers and School to Work Programs that reach out to minority youth in rural communities to assist them in becoming the next generation of health care practitioners.

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A National Agenda for Rural Minority Health Series
The Need for Responsive Rural Health Delivery Systems
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BACKGROUND

The changing and interlinking dynamics of any community affect that community's health status. For example, it is commonly understood that socioeconomic determinants such as income, educational level and age all affect one's access to health care services, which in turn affects one's health status. A number of studies have shown that minorities have poorer health and elevated mortality levels for many of the leading causes of death. Researchers report that between 1980 and 1990, every health indicator for which data were collected indicated an increasing gap between black and white populations (Amey et al. 1997; Greene et al. 1999; Mueller et al. 1997).

Perhaps not surprisingly, studies also indicate disparities in access to health care services for rural minorities. Health care access is worse for rural minority populations, even in comparison to urban minority populations. (Mueller et al, 1999). Other studies have pointed to the difficulties which minorities experience in obtaining needed medical care (McAuley 1998; Shi et al. 2001; Strickland and Strickland 1996). In many cases, minorities were provided less intensive treatment for their health conditions compared to whites. In addition to access barriers such as uninsurance and lack of adequate transportation, minorities also often experience cultural and language barriers that can impede their access to appropriate health care. According to the 1990 census, 25.1 percent of Asian Americans, 23.8 percent of Hispanics, 4.5 percent of Pacific Islanders, 4 percent of American Indians/Alaska Natives and 0.9 percent of Blacks were linguistically isolated. And the number of people with limited or no proficiency in English is growing.

In the case of rural minorities and migrant farm workers, health care access problems are further exacerbated through the lack of participation in the development and implementation of community-based health care initiatives. Recruitment, retention, training, and promotion of racial and ethnic minorities within the nation's health professions workforce will not only help eliminate disparities in the health care received by minorities, it will improve the health of all Americans. Racial and ethnic minority physicians are, in general, more willing to provide care to poor patients who find themselves with no insurance or public insurance such as Medicaid. Also, minority physicians can

bridge linguistic, cultural, and historical barriers that hamper access to care (Pathman and Konrad, 1996).

The goals of Healthy People 2000 articulated the need to address health disparities for all Americans and there is specific mention of the major disparities between minorities and majority populations. The goals of Healthy People 2010 address issues relating to health care delivery systems for rural residents.

Health delivery systems defined

The U.S. health delivery system is large and complicated enough to defy definition. For purposes of this paper, the health delivery system is understood to include a broad range of health-related activities and organizations, including but not limited to: preventive care, public health, primary, ambulatory and in-patient care, emergency and specialty care, dental care, mental health care, long term care. The fractious nature of the U.S. health care system:

- isn't one system at all, but a conglomeration of activities and organizations

- contributes to its inadequacy with respect to health care for rural minority populations.

Strategies/action steps

A. Increase the recruitment and retention of rural minority providers

1. Develop programs to enhance the identification and recruitment of rural minority providers.

2. Provide incentives to increase the number of high school students who choose health careers with enhancement programs.

3. Implement Centers of Excellence for Rural Minority Providers to increase the number of providers who practice in rural minority communities.

4. Implement an assessment of the number of rural minority professionals by disciplines.

5. Encourage health professions schools to include rural minority rotations in their curriculum.

B. Revise financial and payment mechanisms to ensure reimbursements for rural health care providers

1. Expand insurance coverage for the poor and near poor. The Children's Health Insurance Program (CHIP) represents a large step in the right direction and is benefiting minorities. It seems appropriate that in this time of great national prosperity, further reducing the ranks of the uninsured would be a top national policy priority. The pas-

sage of universal coverage legislation would solve the problem of the lack of health insurance for low-income people.

2. Recommend programmatic changes for reimbursement for rural providers to increase access to health care services for rural minorities.

3. Increase funding for community and migrant health centers.

C. Facilitate linkages with rural minority populations in the health care delivery system

1. Implementation of data collection systems that document the number of rural minorities in Census data collection.

2. Ensure that programs are developed that require participation of rural minorities in health delivery systems.

3. Implement requirements that needs assessments are conducted in rural minority communities to document their health care needs.

4. Implement demonstration projects that facilitate minority participation in rural health care delivery systems.

D. Develop programs and initiatives to improve the health status of rural minority residents

1. Implement programs to address the "best practices" of rural minorities to participate in health delivery services.

2. Develop programs and initiatives to increase the number of rural minorities in preventative services.

3. Develop programs that address the cultural and linguistic needs of rural minorities.

4. Ensure that managed care organizations develop sensitivity to rural minority populations.

Policy recommendations

The authors make the following recommendations to federal and state governments:

1. Promotion of a culturally sensitive delivery system to establish and strengthen primary health care and safety net providers in rural minority communities.

2. Promotion to increase access and awareness to culturally and linguistically appropriate minority health care training for providers.

3. Promotion of building bridges between existing health care delivery services and other rural formal and informal community support systems.

4. Promotion and empowerment of rural minority persons, health groups and local leaders to become involved in their communities to decrease physical, financial, institutional and psychological barriers to health care.

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